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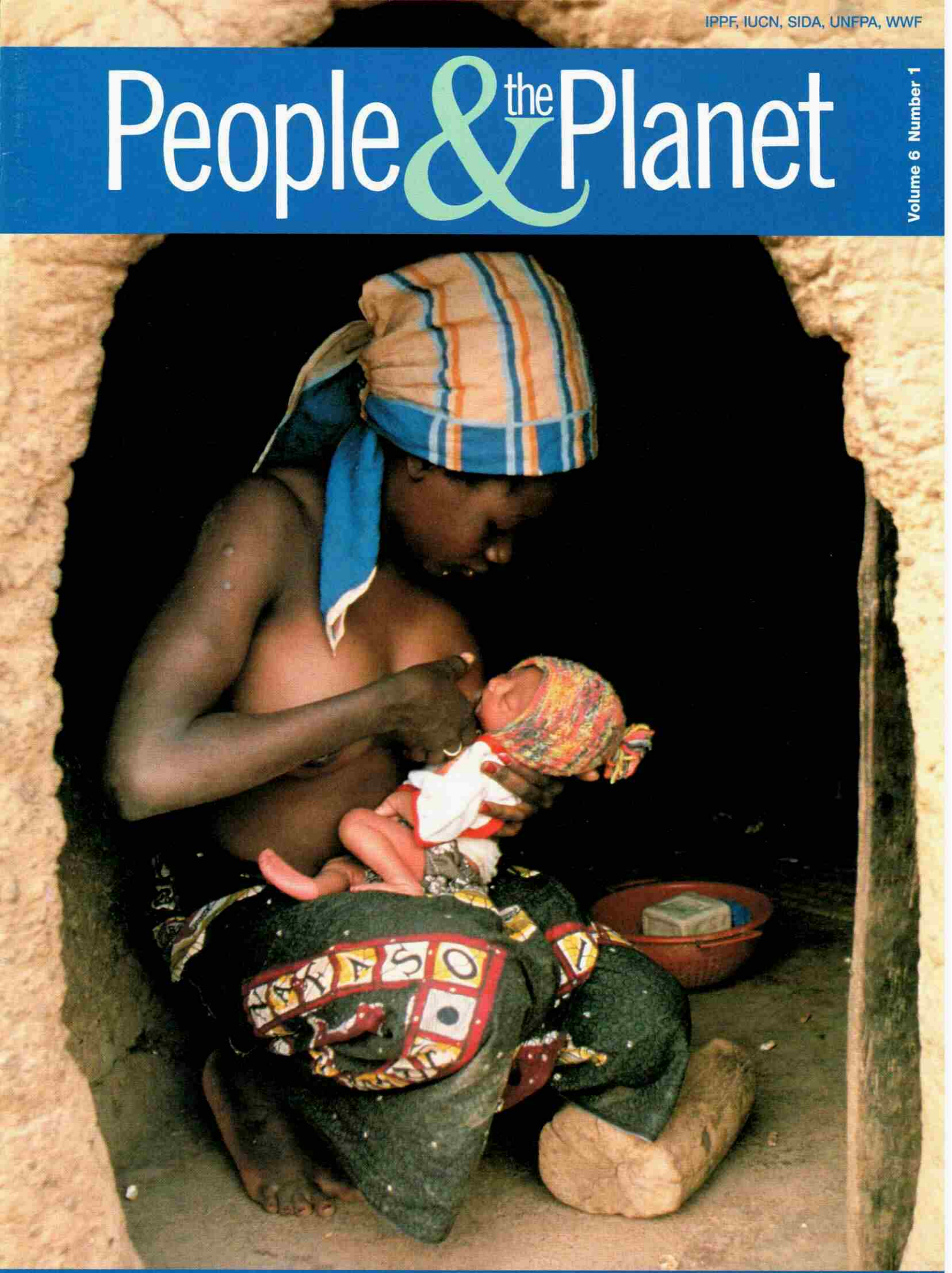
People & the Planet

Volume 6 Number 1



REPRODUCTIVE HEALTH: AN ACHIEVABLE REVOLUTION

Front cover: Pauline Sawadago feeding her newborn baby in her home, Yatenga, Burkina Faso
Credit: Paul Harrison / Still Pictures
Left: A Bangladeshi farmer carries his wife, stricken by tetanus, to the health centre.
Credit: Mark Edwards / Still Pictures

People & the Planet

Contents

Newsfile.....page **4**

Building on the Cairo consensus: Fred Sai, Chairman of the main committee of the Cairo Conference considers how far his hopes for ICPD have been realised.....page **6**

Interview: Dr Nafis Sadik on Cairo and the right course to solve the world's population problems.....page **10**

Missing billions: Shanti Conly reviews progress on the world's pledge to spend US$17 billion a year on population programmes by the end of the century.....page **12**

Saying goodbye to targets: Rami Chhabra reports on India's swift response to reform its reproductive health services in line with the recommendations of the Cairo Conference.....page **14**

Special report: Paul Harrison outlines the main findings of *Caring for the Future* a new agenda for sustainable improvements in the quality of life.....pages **i-iv**

Ending the mutilation: Isabel Mbugua reports on the fresh impetus given to efforts to eliminate female circumcision in Kenya.....page **17**

A partnership for women: Cristina Cavalcanti reports on Brazil's National Commission, monitored by women, set up in response to Cairo.....page **20**

A long road to women's health: Caroline Wheal on South Africa's tentative start on one of its key goals: improving women's health.....page **22**

When South meets South: How South-South collaboration is working out.....page **24**

Gadfly.....page **27**

Associates' news.....page **28**

Book & film reviews...page **30**

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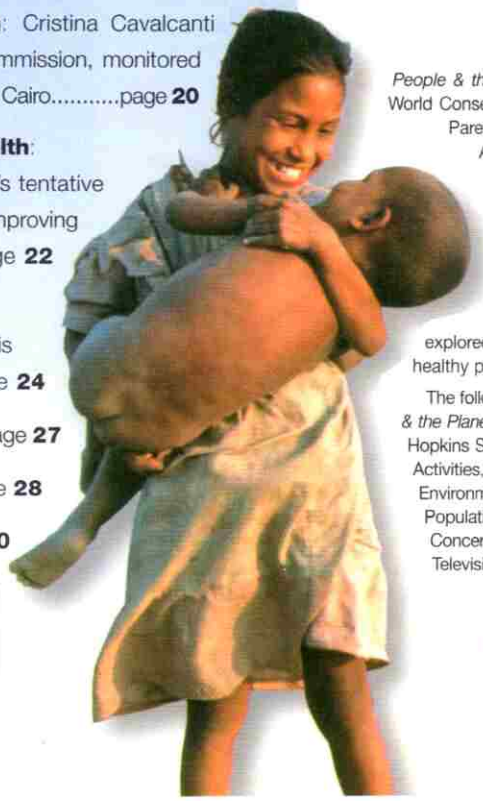

A small price...

The 17-year-old mother lay in a village cart at the gates of the Thana hospital in rural Bangladesh. She had been brought there by her mother on a five-hour journey from the village. She was in severe pain, suffering from obstructed and badly presented labour. On examination a tiny hand of the unborn child was visible. But there was nothing the local doctor was willing or able to do to help. The hospital, serving 300,000 people, had no facilities to operate, and no one trained to do so. Nor was there any hope of the mother finding the 350 taka needed for transport to the Medical College Hospital. This sad story, told to me recently, is true - but the fate of the mother is unknown.

Such tragedies take place across the developing world every minute of the day. Yet simple pre-natal screening at local health centres, or by village health workers, could help plan for such emergencies and save many lives. Happily, this and other aspects of reproductive health care and high quality family planning are on the agenda in many countries thanks to the new emphasis on human needs, rather than on target-driven population programmes, agreed at the Cairo Conference on Population and Development two years ago. If this agenda is actively pursued, accompanied by the other changes in education and opportunities for women called for in Cairo, the gain in human wellbeing will be immense, and the decline in population growth rates which has now taken hold in many countries will be greatly speeded up.

Some countries, as we report from India, have made real headway. Yet there, as elsewhere, the problem of resources has become crucial, as Rami Chhabra makes clear. Without more investment there is a danger that the new emphasis on reproductive health will be more cosmetic than real. Yet enough is now known for political leaders to wake up to the fact that the reproductive revolution is an achievable one. As Shanti Conly points out, the annual $17 billion needed by the year 2000 to ensure reproductive health care for everyone and to slow the human population growth rate to a more sustainable level is less than half the $40 billion that is spent each year on golf. Yet in recent years spending in all developing countries on family planning has been less than $5 billion. Are these the right priorities for the new millennium?

John Rowley

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The following 'associates' are partners in the development and distribution of *People & the Planet:* AVSC International, Audubon, Center for Communication Programs, John Hopkins School of Public Health, Earthwatch, Centre for Development and Population Activities, Family Health International, Futures Group, International Institute for Environment and Development, International Union for the Scientific Study of Population, Pathfinder International, Population Action International, Population Concern, Population Reference Bureau, Royal Swedish Academy of Sciences, Television Trust for the Environment, WWF-Alliance for Religions and Conservation.

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newsfile

FOOD SUMMIT

Sonja Iskov/Still Pictures

Nearly a hundred world leaders, meeting in November for the first ever Food Summit, approved a Declaration on World Food Security and a seven-point Plan of Action to combat hunger, but made no binding commitments, *writes John Madeley.*

The declaration reaffirms "the right of everyone to have access to safe and nutritious food, consistent with the right to adequate food and the fundamental right of everyone to be free from hunger." Leaders thought it "intolerable" that more than 800 million people throughout the world do not have enough food. They pledged "our political will and our common and national commitment to achieving food security for all, and an on-going effort to eradicate hunger in all countries, with an immediate view to reducing the number of under-nourished people to half their present level no later than 2015."

In the Plan of Action, leaders say they will "implement policies aimed at eradicating poverty and inequality ....we will implement, monitor, and follow-up this Plan of Action at all levels in co-operation with the international community."

Representatives of non-governmental organizations monitoring the Summit took the view that the Plan is weak on several key issues, and that more resources and priority will be needed if hunger is to be halved by 2015. Mr Flavio Valente, of the Brazilian organization, Association for Projects Against Hunger (AGORA), said that some of the most important issues were not discussed, "especially the impact of international trade on the lives of the hungry."

At the Summit's final ceremony, 15 countries entered a reservation about the Plan of Action, including the Holy See and nine Arab countries, because of concern that its statements on population may not be compatible with their faiths. The United States entered a reservation because of the judicial implications of the Plan's wording over people's "right to food."

POPULATION CONCERNS

"A growing world population and the urgency of eradicating hunger and malnutrition call for determined policies and effective actions," says the Plan of Action agreed at the World Food Summit in Rome. Enough food for all can be attained, it believes: "the 5.8 billion people in the world today have, on average, 15 per cent more food per person than the global population of 4 billion people had 20 years ago. Yet, further large increases in world food production....are required to feed a growing population, and achieve improved diets."

The "early stabilization of the world population" is required, it says. Also stressed is the need to eliminate "unsustainable patterns of consumption and production, particularly in industrialized countries." The Plan calls for the full integration of "population concerns into development strategies, plans and decision-making, including factors affecting migration."

At the Summit's opening ceremony, Pope John Paul II said it was an "illusion to believe that arbitrary stabilization of the world population could solve the problems of food." Addressing the Summit a day later, Dr Nafis Sadik, Executive Director of the UN Population Fund, avoided a direct response to the Pope's statement, but said: "ensuring the ability of women and men to exercise their reproductive rights will have a decisive impact on population growth and on prospects for food security in the 21st century."

Dr Sadik said that governments needed to make reproductive rights and reproductive health "priorities in national and international development programmes."

See Gadfly, page 27

VIRUNGA TRAGEDY

One of the great tragedies in the history of modern conservation is taking place in Zaire's Virunga Park, according to a report in the first issue of a new UNESCO magazine, *World Heritage Review.*

The park in north-east Zaire, bordering both Uganda and Rwanda, is one of the oldest in Africa, being established in 1925. It is one of unmatched topographical diversity, including lakes, mountains, rainforest and savannah plains. Until recently it also contained a rare wealth of

INCAFO

wildlife, including gorillas, hippos, elephants and rare bird species.

Today, however the park is "but a shadow of its former self," according to Jim Thorsell of IUCN. The trouble, he says, is a combination of population pressure, poaching, civil unrest including an influx of Rwandan refugees, political instability and economic malaise.

Populations around the park have grown immensely over the past 25 years, invading the game reserve surrounding the park, turning it into "an island of nature in a sea of subsistence agriculture." Fishing villages inside the park have more than doubled in size,

over-exploiting the lakes and increasing poaching and commercial pressures.

The existence of military weapons has added to the destruction of wildlife, while park management has been starved of funds. Some 40,000 of the million Rwandan refugees along the park borders are entering the park every day in search of wood and meat. Huge areas have been deforested.

According to Thorsell it will take millions of dollars of external support and at least a decade if Virunga is to be taken off the World Heritage site Danger List.

To subscribe to *World Heritage Review*, Fax: (32 2) 538 08 48, or in the UK Tel: 0171 873 8409.

SILENT PANDEMIC

More than a million women and children died from the complications of reproductive tract infections (RTIs) every year during the 1990s. But worldwide the issue is masked by a culture of silence and a lack of information.

That is the message of a Panos Briefing report, issued in December, which says that the burden of RTIs falls most heavily on women of reproductive age and newborn children.

Infections acquired during unsafe childbirth, illegal and unsafe abortion and unsafe sex account for over 25 per cent of all disability of African women between the ages of 15 and 44. HIV infections and AIDS account for another 25 per cent (not including deaths from AIDS).

RTIs cause a heavy emotional burden, especially when they damage fertility, says the report. While about 5 per cent of women worldwide are unable to bear children due to some inherited or hormonal disorder, a much larger number are rendered infertile by damage to their reproductive tract.

Untreated sexually transmitted diseases are also a significant factor in the spread of HIV in poor countries, with most sexually transmitted infections transmitted more easily from men to women than vice versa.

Good services for the control of such infections should be a fundamental part of any health system including family planning services, the report concludes, and prevention and treatment of STDs is an essential prerequisite in the control of AIDS.

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FOREST LAWS CHALLENGED

A much criticised law from the colonial era that still governs the management of forests in India is likely to be changed after a row over the rights of an indigenous tribe living on the edge of the northern valley town of

Neil Cooper/Panos Pictures

Dehradun, *writes Rahul Verma.*

The large tribe of Van Gujjars, meaning forest people, was drawn into a people-park conflict four years ago when forest authorities decided to evict them from an 825-square kilometre forest area in the Himalayan foothills.

The area includes three wildlife sanctuaries that the Indian government proposes to turn into a protected national park. Citing the Indian Forest Act of 1927 and the Wildlife Act of 1972 which seek to restrict the movement of local people in national parks, authorities demanded the eviction of some 15,000 Van Gujjars in the proposed park area.

The Van Gujjars a nomadic, pastoral and Islamic tribe live in the plains of the park in the winter months and migrate to the mountains every summer with their families and buffaloes. The authorities claimed that the buffaloes cause deforestation and erosion, but experts from Wye College in England found that the tree crowns were relatively unaffected while the lopped trees increased ground vegetation and decreased the likelihood of erosion. The Van Gujjars are vegetarians and impose no threat to wildlife.

After a prolonged and high-profile struggle, the park authorities have finally rescinded the order and campaigners are now seeking to expel the forest guards and park officials.

India's new environment minister, Jai Narain Prasad Nishad, responding to the Van Gujjar campaign has told parliament that both the 1927 and 1972 Acts will be changed because of "the recent emphasis on involvement of local communities in protection and maintenance of forests..."

"These are encouraging signals," says Avdhash Kaushal, chairperson of a Dehradun-based non-governmental organization, the Rural Litigation and Entitlement Kendra (RLEK) which organized the Van Gujjars and spearheaded their agitation.

The NGO has now taken its campaign to the World Bank saying it should take into account the level of community participation in forest management before loaning or granting developing countries funds for the preservation of biodiversity under the Global Environment Facility.

Kaushal says the Bank, under its Ecodevelopment Project, will give India $48 million in soft loans and grants for the preservation of biodiversity in seven protected areas. The country has 75 national parks and 421 sanctuaries covering 14 million hectares of land - 4.3 per cent of the total land - almost exclusively managed by forest department officials.

Panos Features

POISONED CORAL

Two major initiatives have developed from the eighth International Coral Reef Symposium held in Panama City last June, *writes Don Hinrichsen.* This formally declared 1997 to be the Year of the Reef, and agreed upon a new drive to determine the state of coral resources worldwide.

This Rapid Assessment Procedure aims to provide the facts on which management plans can be put in place as soon as possible.

Many activities are now planned around the Year of the Reef, mainly focused on public education. If the reefs are to be saved, it was agreed, a broad public constituency must be created for conserving them.

More than 1,000 scientists from 60 countries participated in the symposium, one of the largest conclaves of marine biologists and other marine experts to ever gather in one place at the same time.

The reason for the heightened interest in the fate of the world's coral reefs is the fact that recent surveys and studies reveal that we are losing this wealth of biodiversity faster than tropical rainforests. Of the world's 600,000 square kilometres of reefs, roughly 70 per cent are endangered and threatened. If nothing is done to conserve and manage coral resources, we may lose three-quarters of them in 40 years.

Coral reefs are referred to as the "rainforests of the sea" because of their high species diversity and productivity. "Coral reefs," explains Robert Ginsburg, Professor of Marine Geology at the University of Miami, "are self-contained, self-sufficient cities flourishing beneath the seas. The corals are the apartment buildings - each with its own garden - providing shelter [and food] for the myriad plant and animal life that lives within the community." ■

As a contribution to the Year of the Reef, the next issue of *People & the Planet* will look at the state of the world's reefs and the efforts being made to save them.

TVE

JOICFP

Fred Sai was Chairman of the Main Committee of the International Conference on Population and Development held in Cairo in 1994 and President of the International Planned Parenthood Federation from 1989 to 1995. He is Chairman of Ghana's National Population Council. He considers here how far his hopes for ICPD have been realized, and looks especially at its implications for Africa.

Building on the Cai

An underestimated achievement of the Cairo Conference was the avoidance of major North-South splits. To me, this was largely because the conference preparatory process and the Programme of Action clearly recognized that population as a global problem is not simply one of increasing numbers and therefore mainly a developing country issue. It is intimately woven into sustainable development and environment problems.

It was accepted early on in the preparatory process that overconsumption, extravagant lifestyles and excessive waste production in the wealthier Northern countries contribute to global population and sustainable development problems just as much as rapid population growth in the poorer South - if not more. Of course, tackling these problems is not proving easy - and the political will to do so seems very weak.

However, the main achievement of the Conference to most people was the acceptance that population growth problems cannot be tackled through a macro numbers approach: solutions must be found at the micro level. Programmes must be based on a proper understanding of people and their needs as individuals and communities, on the status of women, and must represent a genuine effort to help meet such needs in a caring and sensitive manner. The basis of fertility regulation programmes was to be sexual and reproductive health care.

My main hope at the end of the Cairo Conference was that the far-reaching and radical ICPD recommendations would give added courage to those governments, especially in Africa, who are still unsure about the place of population policies and programmes in overall development, and that they would be ready and willing to support the evolution of such policies as quickly as feasible.

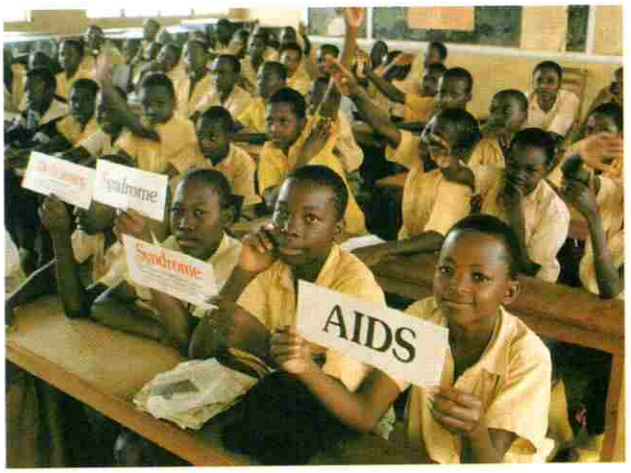
Unfortunately, there has not been a rush to develop population policies as such. I believe though that there has been quite an increase in genuine efforts to try to implement the policies already in place, and to translate agreements which were made through the World Health Organization, the World Bank and other international organizations to give population and family planning a much higher programme priority.

One bonus is that the reproductive health approach seems to have harmonized the thinking of African leaders themselves about the acceptability of family planning. When I was working in the World Bank one of the problems that was constantly being debated was whether population programmes and projects were going to be acceptable to the Africans: the consensus was that they were acceptable, providing they were presented as a component part of family health or maternal and child health.

Bearing in mind the ruinous maternal mortality rates that persist in most African countries, it is not surprising that African governments have readily accepted the ICPD idea of expanding the programmatic base in terms of total reproductive health, especially as ICPD has woken Africa up to the fact that sexually transmitted diseases, now including the deadly HIV, are controllable and manageable and not something that should be accepted as a normal part of life. STD/HIV awareness creation is a major effort in many countries now.

New alliances

What remains still to be done is to translate this idea into all-embracing reproductive health care programmes which can deal with the whole life cycle of events related to sexuality, human reproduction and therefore safe motherhood, abortion, teenage sexual activity, sexually transmitted disease, and many functional and organic diseases involving the reproductive system. Services to meet these needs cannot all be planned and catered for through the traditional health care delivery system, let alone the usual family planning set up: countries really need to understand that implementation can no longer be done just by a single agency. We need to harmonize the activities of a whole range of governmental and non-governmental agencies to respond better to people's needs.



Jorgen Schytte/Still Pictures

There is evidence that this is beginning to happen. With UNFPA leadership, the UN agencies are co-operating better among themselves on this issue, they are collaborating

Top left: Fred Sai
Below left: School children receive AIDS education, Uganda
Right: Pregnant mother with child, Uganda

ro consensus

better with non-governmental organizations, and the NGOs themselves are starting to form more strategic alliances, and not just working in a vacuum, as many of them traditionally did.

Even more satisfying to me is the fact that there is more co-operation at the field level than at the central national level. At the district level, or the smallest administrative unit of a country, the leaders of agriculture, health and so on know each other and they usually can be brought together to consider a problem in terms of the community. It is when we get to the central national level that difficult problems arise. Ministries, organized departmentally, have set budget lines which cannot easily be used for joint projects with other departments or other ministries. The question of how this problem can be overcome is plaguing many planners.

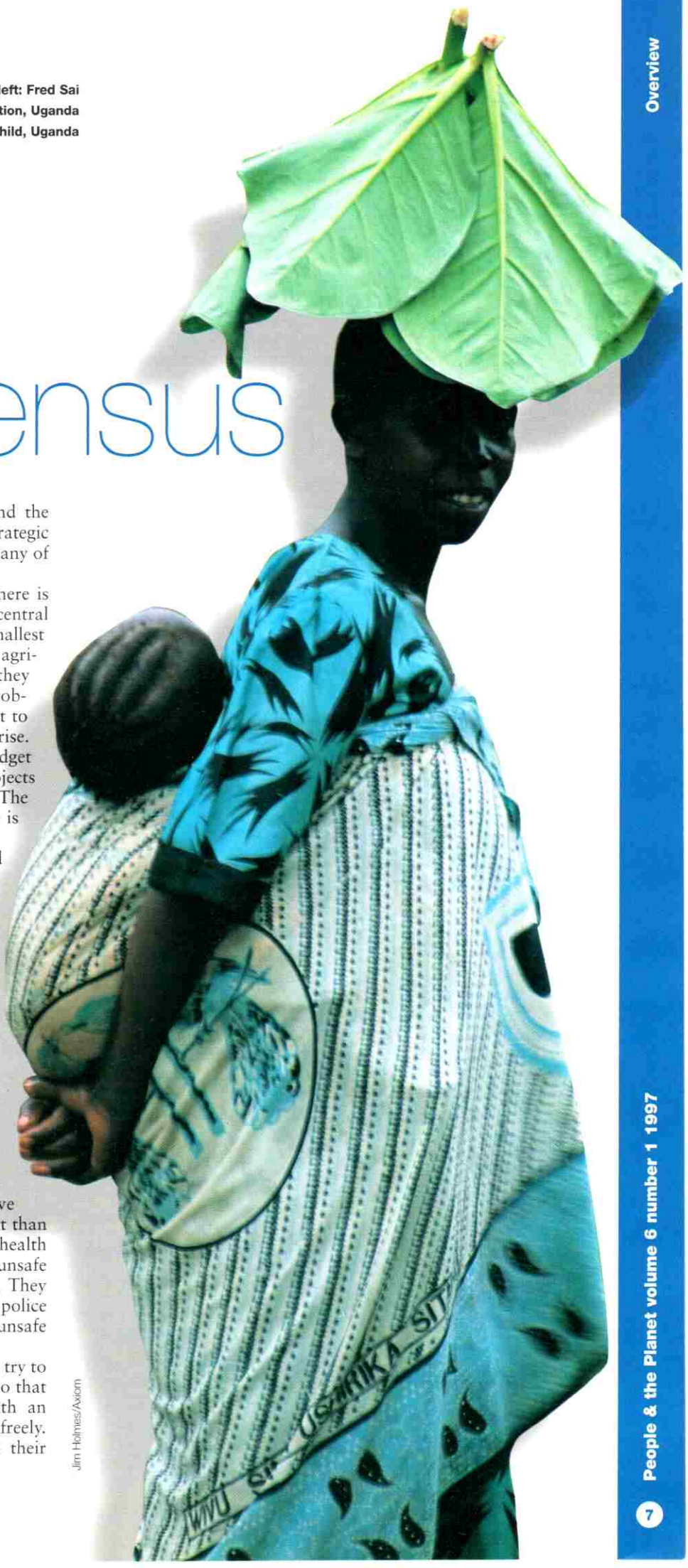
In this respect we must be realistic and build upon what is already on the ground. Efforts to develop models and approaches are on the way in many countries.

Young people

One of the amazing achievements of Cairo was to get a real international consensus on subjects which had previously been considered to be too 'sensitive' for big meetings of this kind: I am particularly thinking of adolescent sexuality, female genital mutilation and unsafe abortion.

There is already some evidence that some governments and organizations are getting more active in opposing unsafe abortion and even reforming archaic laws - although the opposition too is getting more active, because they can never accept that more liberal laws can help save women's lives. I believe that even more important than changing the law is to make the doctors, and health workers generally, understand the true impact of unsafe abortion and to document what is happening. They must also work sympathetically and refuse to be police informers. Associations for the prevention of unsafe abortion are proving helpful in some countries.

More people now realize that it is important to try to remove the criminality and guilt from abortion, so that women who find themselves in difficulties with an unplanned pregnancy can talk to people more freely. Doctors, too, are becoming less judgmental in their approach to unwanted pregnancies.



Jim Holmes/Axiom

The most neglected tragedy...

For a decade the figure of 500,000 maternal deaths a year has been part of the statistical liturgy. Now, new estimates are showing that the number of women who die each year in pregnancy and childbirth is probably closer to 600,000.

But before the new estimates replace the old as a way of packaging up the problem, it should be said that a mistake has been made in allowing statistics such as these to slip into easy usage. For these are not deaths like other deaths, and death is only a part of the story they have to tell.

They die, these hundreds of thousands of women whose lives come to an end in their teens and twenties and thirties, in ways that set them apart from the normal run of human experience.

Over 200,000 die of haemorrhaging, violently pumping blood onto the floor of the bus or bullock cart or blood-soaked stretcher as their families and friends search in vain for help.

About 75,000 more die from attempting to abort their pregnancy themselves. Some will take drugs or submit to violent massage. Alone or assisted many, choose to insert a sharp object - a straightened coat-hanger, a knitting needle, or a sharpened stick through the vagina into the uterus. Some 50,000 women and girls attempt such procedures every day. Most survive, though often with crippling discomfort, pelvic inflammatory disease and a continuing foul discharge. And some do not survive: with punctured uterus and infected wound, they die in pain and alone, bleeding and frightened and ashamed.

Perhaps 75,000 more die with brain and kidney damage in the convulsions of *eclampsia*, a dangerous condition that can arise in late pregnancy and has been described by a survivor as "the worst feeling in the world that can possibly be imagined."

Another 100,000 die of *sepsis*, the bloodstream poisoned by a rising infection from an unhealed uterus or from retained pieces of placenta, bringing fever and hallucinations and appalling pain.

Smaller but still significant numbers die of an *anaemia* so severe that the muscles of the heart fail. And as many as 40,000 a year die of obstructed labour - days of futile contractions repeatedly grinding down the skull of an already asphyxiated baby onto the soft tissues of a pelvis that is just too small.

But the numbers of dead alone do not reveal the full scale of this tragedy. For every woman who dies, approximately 30 more incur injuries, infections, and disabilities which are usually untreated and unspoken of, and which are often humiliating and painful, debilitating and lifelong.

This means that at least 12 million women a year sustain the kind of damage in pregnancy and childbirth that will have a profound effect on their lives. And even allowing for the fact the some women will suffer such injuries more than once during their child-bearing years, the cumulative total of those affected can be conservatively estimated at some 300 million, or more than a quarter of the adult women now alive in the developing world.

It is therefore no exaggeration to say that the issue of maternal mortality and morbidity, locked fast in its conspiracy of silence, is in scale and severity the most neglected tragedy of our times. *Peter Adamson*

Extracted from The Progress of Nations, *UNICEF, 1996.*

Post-abortion counselling, which has been neglected in the past, is now being more widely used. This too creates a strategic alliance between the hospital services, the clinical services and the family planning associations.

The other related area where Cairo has certainly been a catalyst for change is in trying to give some visibility and support to emergency contraception. It is in my view one of the contraceptive areas that will be most acceptable to younger people who, because they are generally not in regular sexual unions, find the Pill not very attractive.

In fact, ICPD has given a major impetus to the whole area of adolescent sexual and reproductive health, and to the involvement of young people themselves in programme design and management. Adolescence needs to be viewed not simply in terms of the problems that it raises, but in terms of a real change that has occurred throughout human society, as education and training needs have led to a lengthening of the period of social and psychological development.

This is not simply a developing country problem; in fact in some respects it is an even more serious problem in industrialized countries, and therefore it offers great potential for the interchange of programme approaches and experiences between the industrialized and the developing world. Non-governmental organizations, especially family planning associations, are probably best placed to promote such interchange.

ICPDL

South-South

The closer involvement of NGOs was stressed at ICPD - another change of emphasis from previous population conferences - and the Programme of Action calls for a "broad and effective partnership between governments and the non-governmental sector in delivering reproductive health information and services". Traditionally NGOs have played an important role in providing information and services to groups in society not well-served by government programmes, such as the poor, ethnic minorities, adolescents, prostitutes and so on. They have also addressed sensitive issues stressed at ICPD such as abortion, violence against women and female genital mutilation. Already there is evidence that

governments are turning to NGOs to help them implement the Programmes of Action which they signed up to in Cairo and Beijing.

NGOs can also help in other areas which ICPD stressed, such as the decentralization of public health programmes to promote community participation in reproductive health care. ICPD rightly called for the commitment and involvement of the people themselves, and an excellent example of making this work in practice is the Africa Agenda undertaken with the support of several multilateral and bilateral agencies. This is an approach whereby research institutions help to find out how communities perceive their population and family planning needs, how they would like to see problems tackled, and the extent to which they would be prepared to be actively involved.

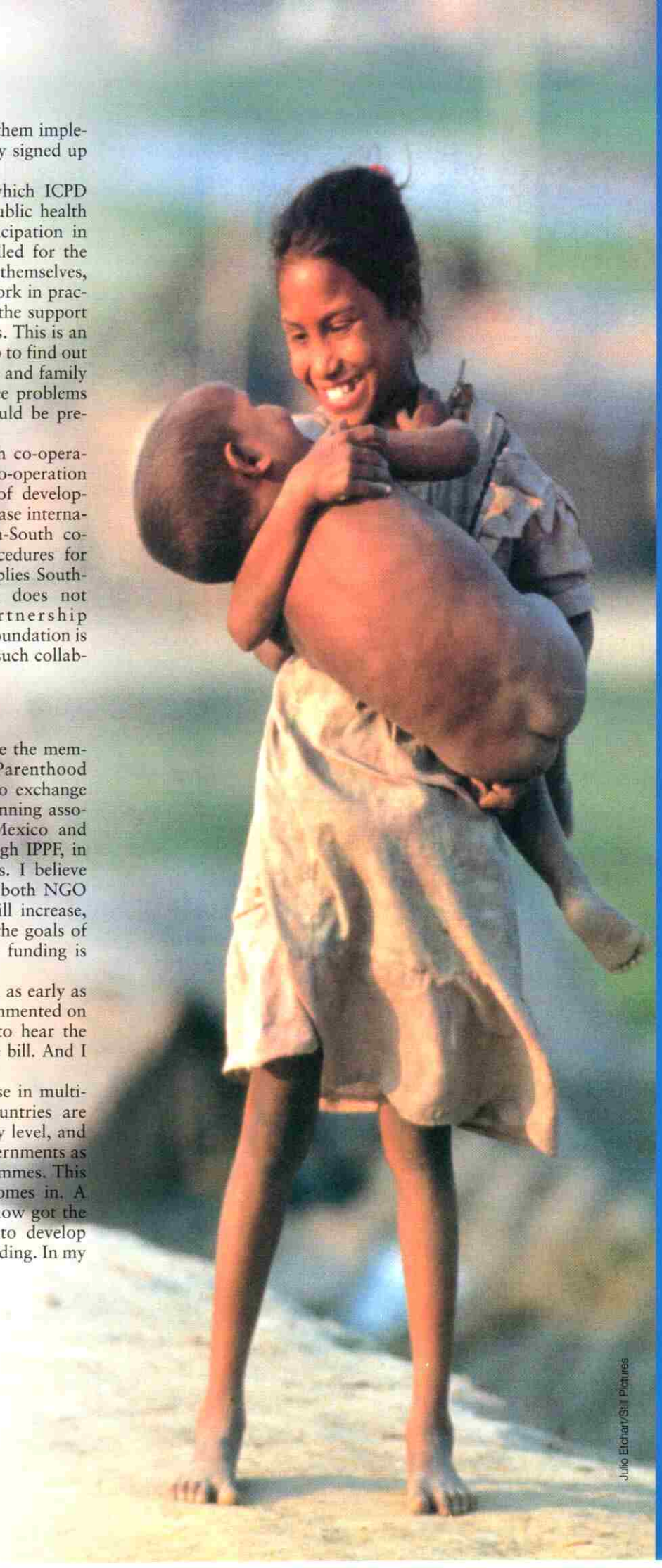
Another area of progress is South-South co-operation. As ICPD underlined, "South-South co-operation at all levels is an important instrument of development" - indeed, one objective was "to increase international financial assistance to direct South-South co-operation and to facilitate financing procedures for direct South-South co-operation." This implies South-South government co-operation, but it does not exclude NGOs. The South-South Partnership Programme sponsored by the Rockefeller Foundation is an example of the potential that exists for such collaboration (see pages 24-25).

Finding funds

NGOs with an international outreach - like the members of the International Planned Parenthood Federation - are particularly well placed to exchange experience, and well-established family planning associations, like those in India, Thailand, Mexico and Morocco, have already participated, through IPPF, in information exchange through study tours. I believe that South-South co-operation - involving both NGO and governmental alliances - must and will increase, and will play a valuable role in achieving the goals of ICPD - providing that adequate Northern funding is available to facilitate the process.

That proviso is quite a critical one. Even as early as the end of the Cairo Conference itself, I commented on the disappointment we of the South felt to hear the shuffling of feet when it came to paying the bill. And I think the shuffling of feet is still going on.

But although the outlook for an increase in multilateral funding is bleak, some donor countries are beginning to put the monies at the embassy level, and this funding can be tapped by national governments as well as NGOs if they develop good programmes. This is where South to South collaboration comes in. A good number of Southern countries have now got the necessary expertise and can help others to develop good programmes and present these for funding. In my view, that is the way to go. ■



Julio Etchart/Still Pictures

Left: AIDS awareness t-shirt in Africa
Right: Bangladeshi girl carrying her baby brother

The Cairo Conference has set the world on the right course to solve its population problems says **Dr Nafis Sadik**, Executive Director of the UN Population Fund (UNFPA) in this interview with the Editor of *People & the Planet*. All that is needed now are the resources.

Maggie Hallahan /Network Images

On course for the 21st century?

People & Planet: It is now more than two years since the Cairo Conference signalled a new consensus on how the world should approach the great issues of population and development. You succeeded then in persuading governments to move away from demographic targets and to set specific social goals. These included reductions in maternal, child and infant mortality, and improvements in education, especially for girls. Has a start been made on these?

Nafis Sadik: We are moving quite well on health and education, with a particular focus on girls. In the UN there is agreement amongst all the organizations concerned, including UNFPA, about what the content of basic education should be. All countries have set targets by which time they should get all children enrolled.

In the health area, we are still working on the what 'basic health services for all' means. Although we have the Alma Ata Conference as the guide it is too broad and doesn't help countries select priority areas. Of course, one area of basic health care is the reproductive health package which is being pushed independently. In the process, it will, I believe, help other aspects of health care to develop.

The second goal of the Conference was a series of activities to improve the power and status of women. These included tackling violence against women, combating gender discrimination, enforcing laws on the age of marriage, eliminating female genital mutilation, encouraging father's responsibilities and increasing the earning power of women. Have you seen any progress in these areas?

On very specific things like female genital mutilation, many things are happening. For the first time, countries themselves are taking some action. Some countries have changed their laws, others are trying to see how that practice can be replaced by something more positive.

On sexual violence, there is more public discussion than ever before. I'm not sure that things have changed dramatically as far as the role and social status of women is concerned but the fact that attention is being paid to education and health for women - maternal mortality reduction is a very specific goal - will help the status of women.

Public rhetoric on the need to have equality for women is very strong. But some countries have gone further. India, for example, has passed a law on local government, with 33 per cent of seats to be reserved for women, and now they are discussing a law to have 33 per cent of seats to be reserved at all levels. That will be a major breakthrough because then women will have some political power. Elsewhere, I regret, rhetoric remains much louder than action.

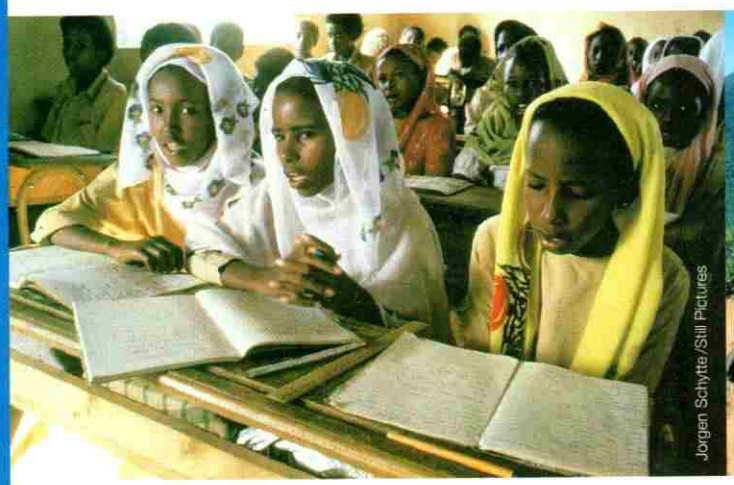
The biggest breakthrough in Cairo was undoubtedly the emphasis on the broad approach to reproductive health, including family planning, which emphasized the importance of the quality of care, the involvement of men as well as women, the needs of adolescents and growing role of non-governmental agencies. What is happening in that area?

I'm very pleased with the response from all countries. I was a bit worried that countries may have some difficulty in adopting the concept. In practice, it has been accepted very readily. But countries are having some difficulty deciding on the priorities at the local service level and we still haven't provided them with adequate guidelines. These are now ready.

Of course these will have to be applied differentially in different countries depending on their level of development.

Have you seen any actual switch of resources towards these areas?

There is no doubt that governments are putting more resources into the reproductive health package. I see that in Africa, and in many Asian and Latin American countries as well as in several Central American countries, such as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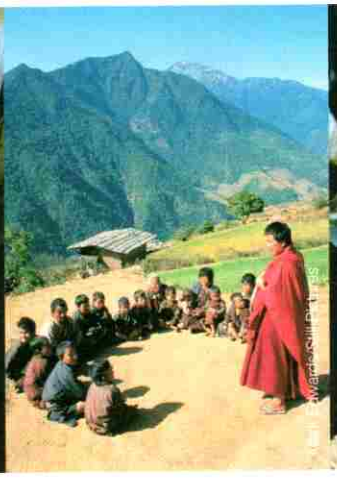
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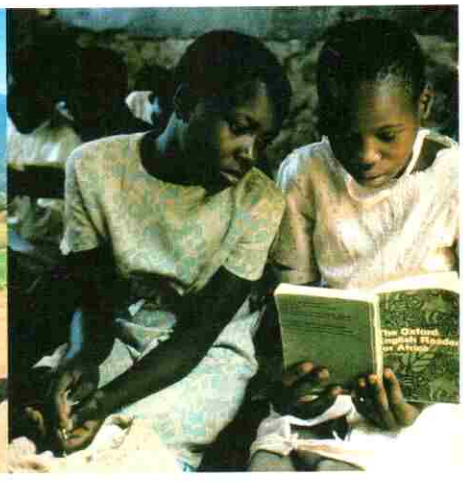

Honduras, El Salvador and Nicaragua.

There is still controversy over whether adolescents should get contraceptive services. But sex education is definitely on the agenda.

On the other hand most countries could do a lot more. There is still this feeling that pregnancy is a normal event and therefore 'what is this big fuss about?' We need to get people to understand that while pregnancy is a normal event, large numbers of women suffer and die in a way that is 99 per cent preventable. That fact is not yet understood.

Can you give some more examples of countries where policy has begun to change following Cairo?

India is a really big example. It has dropped all its targets and quotas in family planning, it has repositioned family planning as part of a broader reproductive health package. The government has mapped all their states' service delivery points and the level of services and has suggested to states how they should implement the package of reproductive health services. India is a very good example of how you can do this differentially because the level of development of different states varies widely.

Brazil which has set up a Commission on Population and Development, is another example. It includes many of the NGOs which participated in ICPD as members, and its main focus is how to implement the Cairo agenda. It is especially concerned to promote a gender-specific agenda, to get women more involved in planning the programmes and to involve non-government agencies and local communities in designing and monitoring services.

The intention is to make sure that women and men have the access to all aspects of reproductive health, addressing the family planning element but also addressing the maternal health element very strongly, including HIV/AIDS and sexual violence. All the things dealt with in Cairo are being addressed by this Commission and mainly at the local level and it is linked to another big programme called the Solidarity Programme which involves local community leaders.

Other countries like Egypt where female genital mutilation is one of the big problems, has finally come out and has decided that FGM is against the law and that anyone found doing it will be prosecuted. The new Minister of Population is also the Minister of Health, so health and population have been merged and the delivery of services is being carried out jointly. The NGO community in Egypt will be doing a lot of the monitoring of the implementation of the Cairo Programme of Action.

I believe Peru is also a good example?

Peru is an excellent example in which the President has really embraced Cairo. He was one of the presidents who really knew the content of the Cairo document. He also made a very strong speech in Beijing on reproductive health.

I visited Peru and spent a day travelling with President Fujimori to remote parts of the country. At every gathering he mingles with the crowd and makes a point of talking about reproductive health and family planning. He insists that the women must be able to decide on the number of children they have because they're the ones having the child. He is very strong on women's rights and on reproductive health and family planning.

Cairo set a target of $17 billion to be spent on reproductive health services by the Year 2000, two-thirds of that to come from developing countries and a third, or some $ 5.7 billion, from the international donors. How optimistic are you that this target will be met?

Developing countries are making a big effort and I hope that later this year (1997) I'll have some figures on how much they themselves are investing. There's no question that they are increasing their spending in this area.

On the donor side 1995 saw a very positive response from the entire donor community. But 1996 was a bit of a disappointment. The biggest disappointment is of course the United States. And that one country is bringing down the total world volume. They have reduced their aid budget by 35 per cent.

On the positive side, many European countries are keeping up their effort and the European Commission is coming into the picture. Once they really get going, their contribution could be significant.

Some people point to the fact that overseas aid generally is atrophying and is now lower than it has been for some time. Do you sense a weakening of commitment to these social sectors?

Development assistance, in general, all over the world is not increasing. But that is all the more reason for a better focus on countries which really need help and on the sectors where external assistance really makes a difference: in population, environment, gender issues, human rights.

We have to raise the public consciousness. We have to get more public support for our programmes, in Europe but also in the United States.

Finally, how confident are you that by the end of the century the world will be on course, more or less, for what was decided in Cairo?

I'm very optimistic that the momentum of Cairo is being maintained. We have to work hard to keep that enthusiasm going. If developing countries can also see that there will be resource flows because they are making the effort, then many more will make an effort.

That is one of the things that I keep trying to tell donors, that the response from the developing countries is very strong. They have made the policy commitment, and to the extent possible, they are making a resource commitment. If I can only convince donors that we have this commitment and that the policies are right, then I'm reasonably optimistic that we will be on course for the 21st century. ■

Left to right : Educating girls in Eritrea
Monk giving family planning lecture, Bhutan
Under resourced school, Uganda
School girls, Haiti
Electronics class, India

Missing bill

The promise of the Cairo Conference was to spend $17 billion a year on population programmes by the end of the century. **Shanti Conly**, Director of Policy Research at Population Action International, in Washington, reports on the world's response.

"Without resources...the Programme of Action will remain a paper promise." So said Dr Nafis Sadik, Executive Director of the UN Population Fund and Secretary General of the International Conference on Population and Development (ICPD) as that meeting came to an end in Cairo in the summer of 1994.

Clearly, changes in policies and programmes in countries such as India, South Africa and Brazil, as described in this issue, lie at the heart of the Cairo Action Plan. Yet Dr Sadik's words underscore the essential need for commitment of adequate funds by both developing and developed countries if the conference goals are to be turned into reality.

Funding goals

Expenditures on family planning in developing countries in the early 1990s are in the range of $4 billion to $5 billion; little information is available regarding expenditures on other reproductive health services. The Programme of Action calls for a roughly four-fold increase in total annual financial commitments for population programmes to $17 billion by the end of the decade, and a further increase to $22 billion by 2015. This quantum leap reflects the projected doubling of the number of women, men and adolescents in need of services, and the consensus in Cairo that existing efforts must be improved as well as expanded to include other reproductive health services.

The Programme of Action estimates family planning services will require roughly two-thirds of these projected resource needs; the remaining third is needed to support an expanded (although still limited) package of related health services, such as basic maternity care and prevention of AIDS and other sexually transmitted infections. The Programme also calls for donor countries to increase their share of contributions from the current one-fourth to about one-third, or to $5.7 billion in the year 2000. These estimates are all in 1993 constant dollars; resource needs in current dollars will be significantly higher.

These estimates do not include a price tag for the broader social investments - for example on child survival and girls' education - that encourage couples to have smaller families and to delay childbearing. Yet these approaches are an integral part of the strategy agreed on at Cairo, and will require significant additional investments by both donor and developing countries.

If $17 billion a year sounds like a lot of money for global population programmes, keep in mind that the world spends $40 billion annually - roughly two and a half times this amount - to play golf!

The billion dollar question: what progress have we made, two years later, towards meeting the resource needs identified in the conference document?

Michael MacIntyre

Bilateral Donors

The Cairo conference clearly stimulated a major boost in donor contributions for population activities, following a period of relative stagnation in the early 1990s. Between 1993 and 1994, overall donor contributions jumped by 25 per cent to $1.2 billion. A number of countries increased their contributions again in 1995, including Denmark, Germany, Japan, the Netherlands, the United Kingdom, and the United States - all countries which have provided long-standing support to population work. Australia has also significantly increased its bilateral assistance; Switzerland has made more modest increases.

Dr Michael Bohnet, Deputy Director General of the German Ministry for Economic Co-operation & Development, points out that the Cairo conference spurred Germany to quadruple its population assistance between 1990 and 1995. "Cairo was one of the most successful UN conferences ever. Germany now has more than 20 population and family planning projects in developing countries. This would not have happened without Cairo - the conference changed our national policies." In the spirit of Cairo, Germany and other donors are supporting both family planning and other reproductive health services.

The United States - the largest contributor to population programmes - almost doubled its population funding between 1992 and 1995, to $583 million, while also increasing funding for AIDS and maternal health programmes. In a major setback, however, the Congress cut population funding for 1996 and 1997 by 35 and 30 per cent respectively from the 1995 level. Still, the United States remains by far the largest donor.

Unfortunately, Cairo appears to have had little impact on several countries which have historically been laggards in population assistance - among them, France, Italy, Spain, Belgium and Austria. Some of these countries have large foreign aid commitment, yet none has significantly increased their negligible population funding. Canada and Finland have moved to reverse declines in population aid, but have not restored funding to previous peak levels. Population assistance provided by Norway and Sweden has declined, although these countries still make among the highest per capita contributions.

If the year 2000 funding goal for population assistance is divided according to each country's share of the combined gross national product (GNP) for the industrialized countries, only Norway and Denmark are close to paying their fair share. Even the largest contributors are far behind where they need to be. Equal burden-sharing would require that the United States increase its population and reproductive health aid to roughly $1.9 billion by the year 2000. This compares to an actual US$ contribution of about $742 million in 1995 for population, AIDS and maternal health programmes - prior to the recent budget cuts. Japan would have to increase its contribution of $103 million in 1995 for population and AIDS programmes to $1.2 billion.

A recent downturn in overall devel-

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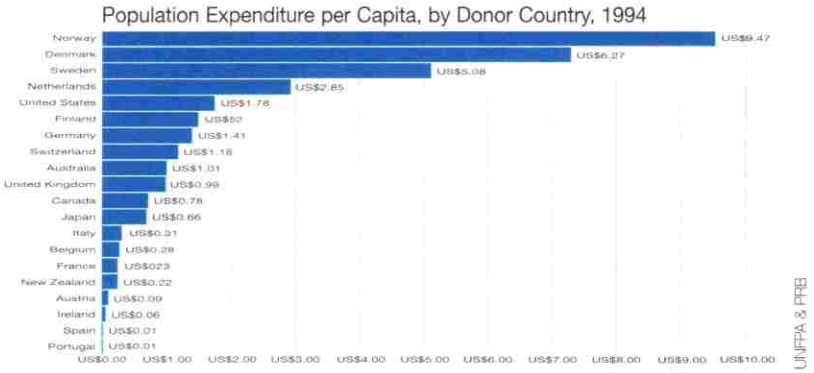


opment assistance also appears to be stalling the momentum from Cairo. Development assistance not only declined in 1995, but fell to the lowest share of combined GNP for the industrialized countries since 1970. A number of donor countries are cutting or putting a ceiling on foreign aid in response to pressure to reduce budget deficits. Although some of these countries appear committed to maintaining support for population work, stagnating or declining foreign aid levels limit the potential for future increases in population assistance.

"We, as a donor community, are not living up to the pledges made at Cairo," says Dr Steven Sinding of the Rockefeller Foundation. "We are only providing roughly a third of what the Cairo document calls for in the year 2000." Sinding sees the decline in development assistance as "ominous" noting that it also jeopardizes achievement of the broader social development goals promoted at Cairo and other recent international conferences.

Multilateral potential

Given the uncertain future of bilateral population aid, multilateral sources take on even greater importance. The Cairo conference spurred the European Union (EU) - which previously provided little population funding - to announce an annual goal of ECU $300 million (U.S. $375 million) in aid to population programmes by the year 2000, and to steadily increase its funding.

The multilateral development banks also represent a potential source of additional funds. The World Bank increased its funding for population and reproductive health to about $600 million in 1996, up from $424 million in 1994, and is also committing large sums to girls' education. The regional development banks have lent very little for population projects over the years, but the Asian Development Bank is increasing its lending in this area.

Developing Countries

In the final analysis the main responsibility for funding population programmes falls squarely on the developing countries themselves. Indeed, about 75 per cent of costs are currently borne by them - primarily by governments, and to a lesser extent by private consumers. Since the Cairo conference, a number of governments, for example in India, Pakistan and Peru, appear to be increasing their funding in this area.

However, a lack of good data on national financial commitments makes it difficult to evaluate the extent to which the developing world overall is meeting its share of the funding increases called for in Cairo. This highlights the urgent need for more systematic efforts to track expenditures for family planning and other reproductive health programmes, in order to hold both developing and donor countries accountable for meeting the goals agreed to in Cairo.

Clearly, however, many developing country governments could increase their contributions. A 1994 Population Action International study found that a relatively few countries - Bangladesh, China, India, Indonesia, Mexico, South Africa, and Turkey - account for roughly 85 per cent of all government expenditures on family planning in developing countries. Costa Rica, Jamaica, Nicaragua, Mauritius, Sri Lanka, Taiwan and Tunisia are smaller countries which provide significant support on a per capita basis. Many other governments spend just pennies per person on family planning, despite its importance to health and development. In much of Latin America, private consumers bear most of the cost of family planning; in most African countries, governments still look to external donors to finance their fledgling programmes.

Consumers could also contribute more. Evidence from many countries - including several relatively poor ones - suggests that private citizens are both willing and able to pay at least some share of the cost of contraceptive services.

Need for partnerships

While wealthier developing countries can bear more of the costs, the poorest countries will continue to need external assistance for some time to come. But donor countries are likely to be more generous if developing country governments are striving to meet the needs of their own citizens. To meet the formidable challenge of raising the resources required by the end of the decade, everyone will have to pay more - donor and developing countries, and developing country governments and citizens. Ultimately, the issue - for both rich and poor - comes down to political will. ■

Shanti Conly is the author or editor of numerous recent PAI publications. Before to joining PAI, she worked with population and development programmes in Bangladesh, Egypt and Pakistan.

Bangladesh: poor country - big effort

In the early 1990s, Bangladesh, a desperately poor country of 120 million people, spent a total of more than $135 million a year on family planning - now used by a remarkable 45 per cent of Bangladeshi women. The government, which has consistently made family planning a high priority, spent about $32 million a year from its own funds on the national family planning programme during this period.

The World Bank and more than a dozen other donors provided another $100 million annually in loan and grant assistance for both family planning and other maternal and child health services. And private citizens spent almost $4 million a year from their own pockets to buy (mostly subsidized) contraceptives on the market.

Bangladesh has shown that it is possible to mobilize significant resources for population work, even in a very poor country, with sufficient political will. The need now is to strengthen the reproductive health approach.

Mark Edwards/Still Pictures

Family planning, Matlab, Bangladesh

Saying goodbye to targets

India, with one-sixth of the world's population, has acted swiftly to reform its reproductive health services in line with the recommendations agreed at the Cairo Conference. Here **Rami Chhabra** sets out the Government's strategy, and comments on some of the problems which remain.

On April last year, India abolished demographic targets for family planning. Such targets no longer figure in the national health reporting systems. The Ministry of Health and Family Welfare emphasizes that this break with the past is final proof of a major shift from a "population control" policy, to reproductive care for women, alongside child health care.

The need for such a shift has been long been beyond dispute. But perspectives differ on how much the present shift signifies a solid transformation of the system.

The April 1 date for this new approach, in a new fiscal year, provided the critics with a fusillade of April Fool cracks. But top programme administrators are unfazed. Feminist and NGO groups - who have long decried targets - have welcomed the step as a victory of sorts. International agencies, which have long argued for an alternative contraceptive mix and a range of reproduction-related services, are exhilarated that the rigor mortis of the sterilization strategy has been finally deconstructed.

"The concept of reproductive health has taken root and the government has recognized that a client-based approach for addressing reproductive health needs is necessary to succeed," says Dr Saroj Pachauri, Regional Director for South and South East Asia of the Population Council.

Dr Pachauri, as part of a World Bank mission team, designed the reproductive and child health services matrix

Sanjeev Saith

for comprehensive Reproductive and Child Health (RCH) services that the Indian government has now further adapted and adopted. These have four dimensions: the prevention of unwanted pregnancy; maternal care which includes ante-natal, delivery and post partum services; child survival services and management of reproductive tract infections and sexually transmitted diseases (RTI/STDs). Filling some of the gaps in the system to implement this approach forms the core of a catalytic $400 million RCH Project, currently under negotiation with World Bank and the European Union, which is expected to be in place at the start of the next fiscal year.

"I conceived 19 times - 9 miscarried and only ten children were born. Of these ten children only five - two boys and three girls survived. I had never heard of family planning. In those days where was there any discussion of such a thing? We worked the fields and gave birth like animals. It is not like today. Now my daughter-in-law has two children and is expecting a third. I don't care whether it is a boy or girl. I will take her for the operation after this and help her to stop."

Barka Devi, Ranikhet, Kumaon Hills, Uttar Pradesh. Extract from Women's Perspectives *A DoorDarshan Television Series. Researched, Directed and Anchored by Rami Chhabra for India's National Network.*

The Ministry's new bible: the official Manual on a Target Free Approach in the Family Welfare Programme, defines the new focus as a change from segregated fertility-reduction target-chasing to an "integrated RCH services approach." The vision is of a client-centred continuum of care, taking in family planning, child survival, safe motherhood and RTI/STD/AIDS prevention.

"This is not laissez faire," asserts J.C. Pant, Secretary in the Government's Department of Family Welfare, the programme's current chief steward. In an interview with *People & the Planet*, he said that "Unlike in the past, this year we are actively changing patterns of functioning that have been set for 50 years. There is bound to be a state of flux for some time, even uneven response across a country as large as India, but there is no vacuum."

"What we are doing is bringing about decentralized Primary Health Centre (PHC)-based planning and implementation," Pant explained. "Instead of top down, we are now working from bottom up. This year, each one of the 21,000 PHCs is conducting its own Needs Assessment Exercise, through grassroots workers in collaboration with the community, particularly involving the *panchayats* (the local government mechanism) where, as you know, one-third of the members are now women.

"The PHC plan will cover all family welfare activities, including materials and supplies. It will outline the operational strategy to achieve the identified objectives. These plans are then being collated at the district, then state and finally country level. In time, the *panchayats* will be also involved in the

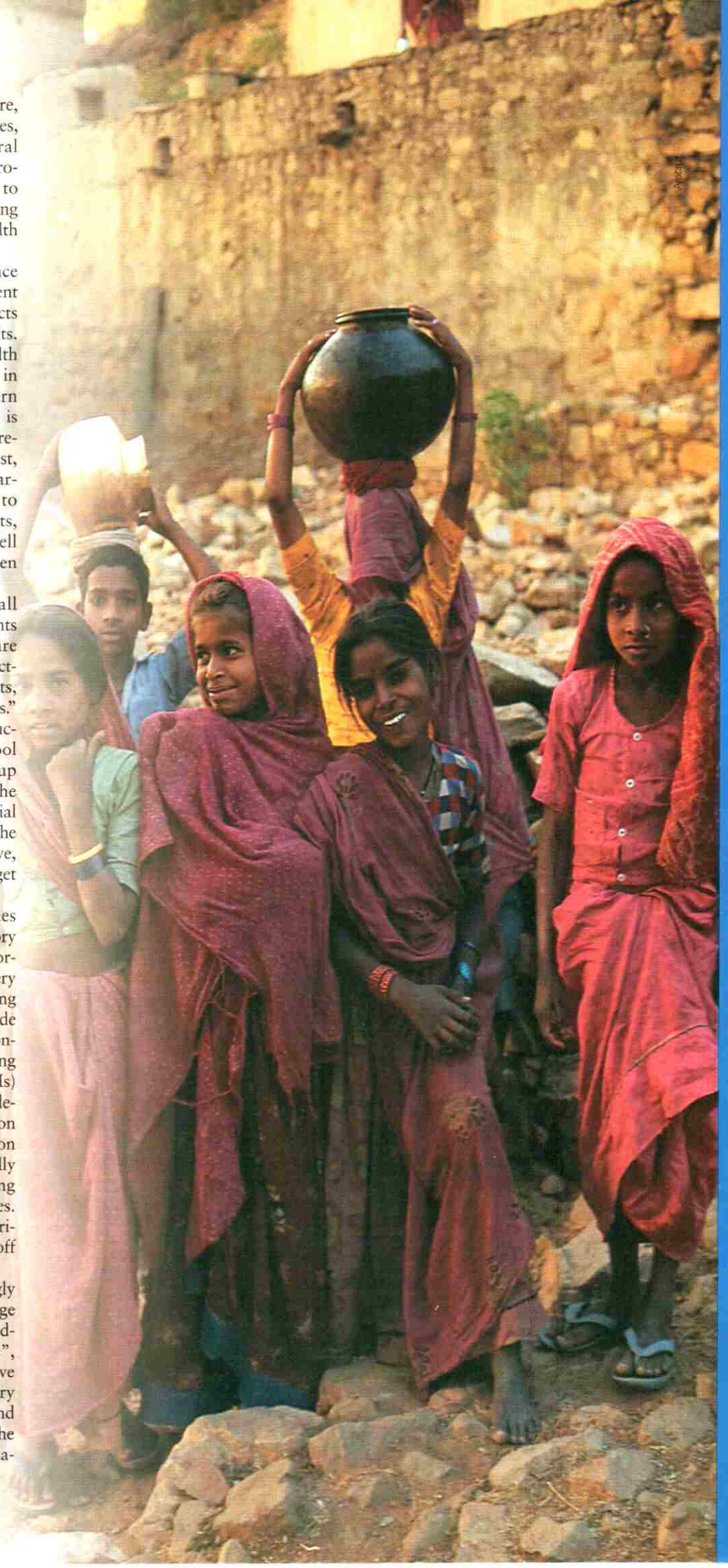
monitoring and feedback. Furthermore, we are working on innovative schemes, such as netting into the Rural Employment Programme funds to provide a tiny complex in each village to site a clean delivery room and a meeting point for reproductive and child health services."

Following the Cairo Conference (ICPD), India launched an experiment with one or two "target free" districts in each of the states, with mixed results. Southern states, with a better health infrastructure generally, fared better in the experiment than the Northern states. But district level leadership is seen to make a critical difference, irrespective of geography. In the largest, most difficult state of Uttar Pradesh target-free Agra District was able to demonstrate dramatic improvements, but target-free Sitapur District fell behind. Similar differences have been demonstrated in Rajasthan.

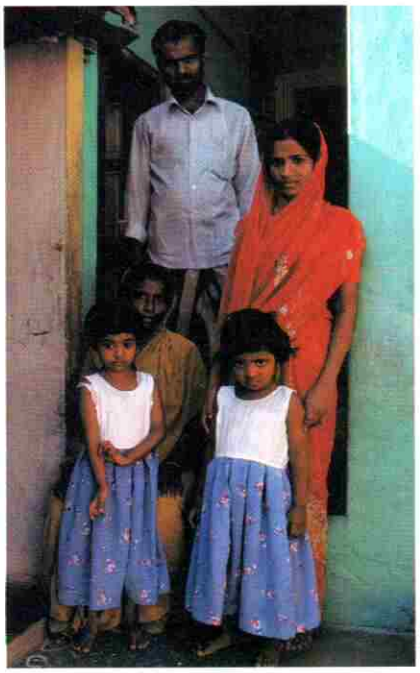
"A hotchpotch year is a small price in long-term investment," points out Pant. "We are now working directly with the districts, alongside the states." Spurred by the success of the school health check-up coverage and the country-wide social mobilization for the Polio Plus initiative, the government opted for the "target free approach" across the country.

The Secretary reiterates: "Duties have been laid down for each category of worker within the PHC system; formats for reporting developed for every level; illustrative guidelines for planning and training made available, alongside manuals for carrying out the new continuum of care approach and orienting the Auxiliary Nurse Midwives (ANMs) and their supervisors. A system of independent rapid survey and evaluation through the country's 18 Population Resource Centres and eight specially constituted regional teams is being developed to ensure needed correctives. I996 was a year of preparation and orientation. We will be ready to take off from April 1997."

A clutch of manuals, painstakingly detailing how to operationally change and manage "a client-centred demand-driven quality services programme", has indeed been introduced. These have reached each of the 21,000 Primary Health Centres in the country. And despite some language constraints, the manuals testify the high-level determination to reverse the existing mindset.



Michael Macintyre


Sanjeev Saith

Now, across the winter months, a back-breaking schedule is lined-up. Senior State health officials from the country's 32 States and Union Territories have undergone two days of training to internalize the new RCH approach. Each of the country's 466 administrative districts has been conducting a similar exercise and then, in turn, will help the nation's 5886 community development blocks to come on the same wavelength.

"Women want family planning, all want it, but who listens to women?"

Group of women, Udaka, Haryana, North India. Extract from Women's Perspectives

Practical application of the theories was demonstrated by the two nation-wide pulse waves for polio eradication in early December and mid-January. It will be followed by a training programme for every one of the over 150,000 ANMs to be conducted, in batches of 40 in each district. All this has acquired the dimension of a manthan, the mythological churning of the ocean that yielded the goddess bearing nectar. There is no questioning the sincerity of those endeavouring to stir gigantic ripples in the 'family welfare' system.

There is also no doubt that there is a corresponding unmet need for family planning in the country - particularly amongst women - that could surge with sympathetic, quality services. The question is whether the documentation and training dose will suffice to inject a dramatic change in the delivery of quality care.

Those familiar with field realities emphasize the need for Reproductive and Child Health services to be only one critical but only one component of a more comprehensive investment in infrastructure for basic health care.

"The exploding communicable disease scenario is a warning signal not to be ignored that the public health system is in disarray. It will not be possible to deliver on reproductive health in isolation," warns Dr Mira Shiva, a well known health activist working with Voluntary Health Association of India, a national NGO with a nationwide health network. "Compartmentalized attitudes of compassion and care can become mere artifices to achieve ends."

Dr Pachauri also acknowledges that: "Reproductive health has to be embedded into the primary health care framework. The reproductive health ideology is defeated without that. It can't be done piecemeal."

Unfortunately, so far the proposed nationwide "integrated RCH strategy" skirts these basic issues. In a situation of acute resource constraint it has curiously chosen to provide the least inputs towards strengthening the most backward parts.

Working on the basis of the proportion of home-based deliveries, it has divided the country into three categories for inputs. As a result, in the very areas of greatest need for RCH attention: the Hindi speaking belt in the North - where maternal, infant and child mortality rates are the highest in the country, family planning acceptance, literacy levels and women's status the lowest and the primary health care system the most dysfunctional - the Auxiliary Nurse Midwives and Traditional Birth Attendants will bear the brunt, with the most skeletal referral back-up from amongst the three categories.

Virtually sidestepped is the important intermediate tier of the PHCs. Only 10 per cent of the primary health centres in these "C class" states are to receive support for maintenance, upgrading and equipment - as opposed to 100 per cent in the A category states of Kerala, Tamil Nadu and Goa. This is just one incongruous example. The final rung of the PHC system, the Community Health Centre - originally envisaged for every 100,000 population with four specialist doctors and surgical and diagnostic back-up - is virtually abandoned for these parts.

"I had six children. My life was full of hardships. It was hard to educate and feed them. I don't want my children to face the same difficulties. So I persuaded all my daughters and daughters-in-law to have smaller families. They have all been operated after two children each."

Sabira Bi, Poonamalee Village, Tamil Nadu. Extract from Women's Perspectives

Although the RCH strategy hopes to secure funds, in the Ninth Plan now under preparation, for another 20,000 female health workers to form a team of two workers in some of the most poorly performing districts, it has proposed no amends for the huge shortfall in the numbers of the state-funded male health workers responsible for basic sanitation, communicable diseases and the only male outreach for reproductive health care.

Resources issues are the key. The RCH Programme has projected a need for Rs.230,000 million over the Ninth Plan - as opposed to the Rs.75,000 million received over the Eighth Plan - to meet the extra costs of the integrated system. External resources are expected to contribute the equivalent of Rs.20,000 million ($1 equals Rs. 36).

"The public health outlay also needs to triple," warns P.P. Chauhan, Government of India's Secretary of Health, beleaguered with Parliament questions on dengue, TB, leprosy, malaria and impending yellow fever outbreaks. "Over the Eighth Plan period the total Centre and State allocation for health was a meagre Rs.75,820 million - less than 1.5 percent of the GDP. We need 6 per cent." Will it come?

The announced "client approach to family welfare and health services" will undoubtedly catapult these issues more squarely to the fore.

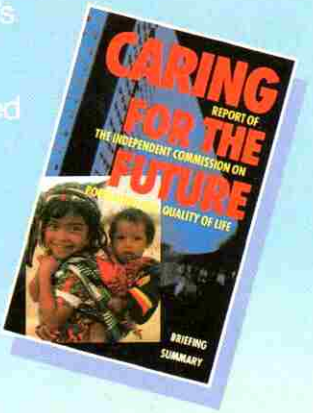
In the last gasp of the millennium the point at issue in India cannot be whether to prioritize reproductive health investment or public health investment. The means have to be found to do both together. Without synergistic action the systemic changes will stay cosmetic. ■

Rami Chhabra is a well-known writer, television commentator and women's activist. A former Advisor, Media and Communications in the Indian Ministry of Health and Family Welfare, she now works as an independent consultant and communicator. Last year her 12-part television series on social issues, *Aarsi Social Watch* was screened nationwide.

Caring for the Future

A new agenda for sustainable improvement in the quality of life.

The Independent Commission on Population and Quality of Life was set up in 1992 and funded by a consortium of seven governments, with the United Nations Population Fund, International Planned Parenthood Federation and World Bank, and several major private foundations. The mission was to develop a fresh vision in matters of population and quality of life. Work began in 1993. As well as its own six sessions the Commission held seven regional hearings and commissioned 62 expert papers. The Commission's president was Maria de Lourdes Pintasilgo, former Prime Minister of Portugal. Its ground-breaking report, *Caring for the Future*, was launched last summer and published in paperback by Oxford University Press, but received little media attention. Here, as a service to our readers, **Paul Harrison** outlines its main findings.



Caring for the Future

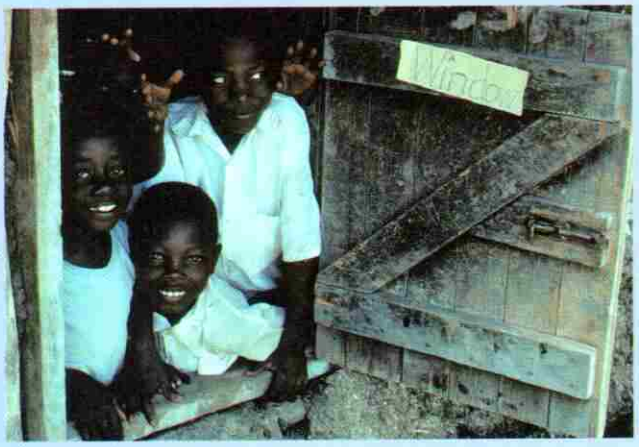
The report of the Independent Commission on Population and Quality of Life, published last July, came at a timely moment. Globally, environmental problems and social tensions are mounting. Population growth is running at 88 millions a year - a record level in numeric terms.

Unemployment is rampant in Eastern and Western Europe and many parts of the developing world. Inequality is growing in most countries. The numbers of absolute poor remains stubbornly high.

At the same time, global politics are dominated by the ideology of the free market. In most parts of the world, governments' role and spending are being cut back in all sectors. Commitment to international actions - other than trade and peacekeeping - are both dwindling.

Against this depressing backdrop, the Commission's report stresses the need for a new sense of mutual responsibility and care at national and international levels. The sustainable quality of life should be placed at the very heart of policy-making by all governments.

The concern should be not just with environmental sustainability, but social sustainability. These should take the place of the prevailing obsession with purely economic development and deregulation regardless of the social and environmental consequences.



Jorgen Schytte/Still Pictures

Finding the money

One of the most innovative features of the report is its exploration of new sources of funding for quality of life rights.

Since 1990 one United Nations conference after another has agreed massive programmes of action on education, children, environment, poverty and so on. These programmes overlap, and they have never been costed comprehensively. The Commission calculates that the total annual cost of all the agreed programmes in aid and concessional loans would be at least $146 billion (see table overleaf).

These funds have not been forthcoming. Instead, aid budgets have been cut back almost everywhere, and there is little prospect of them increasing. Global funding commitments at international conferences had become a mockery, and are now often avoided altogether. The system of international conferences and pledges has been brought into disrepute.

These trends must be reversed and a new dynamism inserted into international co-operation for development.

The first task is for the United Nations to draw up a comprehensive inventory of all internationally agreed priority programmes, with a detailed costing to cut out overlap.

But the world urgently needs a more reliable mechanism for funding these priorities - one that would not be at the mercy of government budget problems. The Commission proposes that the UN should launch detailed studies of a range of new funding mechanisms. These would include tradable carbon dioxide permits, levies on international air and sea transport, telecommunications frequencies and satellites, and an international lottery.

Jorgen Schytte/Still Pictures

The most promising source of major funding would be a new international levy on all global financial dealings. Annual dealings are massive - totalling *more than ten times* the world's annual GNP. And they are often destabilizing for national economic policies.

A tax on spot currency dealings was first proposed in 1972 by US economist James Tobin, as a way of discouraging speculative flows. However, such a tax would encourage dealers to shift into other areas so as to avoid tax. The Commission therefore backs a flat levy on *all* present and future types of global financial transactions - including securities, bonds, shares and financial derivatives.

Even at a very modest rate of 0.01 per cent, such a levy could yield at least $150 billion a year for international purposes. This is two and a half times as much as aid, and close to the sum needed to pay for agreed international priorities. At such a low level, it would not deter legitimate transactions but it might help to deter runs on currencies. The levy would be collected by national banks. A new global priority authority would be needed to distribute the proceeds according to international agreements.

The Commission recommends that the United Nations should initiate studies on the mechanisms and yields of such a levy.

Priorities for aid.

But even with existing levels of development assistance much more could be done to improve the quality of life for those who at present have no quality of life.

Aid is not distributed according to need. Commission calculations show that the poorest countries, with average real incomes per person below $2000 a year, received only $8.23 aid per person in 1991 (see chart). Those with income of $4-5000 received almost ten times as much.

Quality of life sectors such as education, health, family planning and women's development are not getting an adequate

Independent Commission on Population and Quality of Life

share of aid. In 1992 only 29 per cent of aid went to human development and agriculture. UNICEF estimates that the share going to meet basic quality of life needs of the poor was perhaps only a quarter of that.

The Commission recommends that in future aid should focus on the poorest people in the poorest countries. Assistance for countries with real per capita incomes of more than $3000 should no longer be classed as aid. Redistributing their share to countries with real incomes below $2000 would increase aid per person for these countries by 75 per cent.

Aid should focus heavily on sustainable human development, starting with at least the 20 per cent put forward at the World Summit for Social Development in 1995. This should be a first step towards a much greater share.

Human rights

In parallel with the proposals for new funding, the Commission also looked for out new ways of motivating concern, in national governments and in the international community, for the quality of life of the world's poorest.

The Commission advocates a new stress on the body of human rights enshrined in the four major international rights treaties. These are: the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC).

The coverage of these international rights is now very wide. They include the rights to freedom from hunger, to work, to free compulsory primary education, to gender equality, and to primary health care. They also include many aspects of reproductive rights including access to family planning, maternal nutrition and pre-natal and post-natal health care.

The Commission proposes that this system of social and economic rights should be greatly strengthened. Countries that have not signed or ratified the treaties should be encouraged and assisted to do so, so that the rights become universal.

The rights should be more clearly defined, so that it is easy to see when they are being infringed. Basic minima should be set that must be reached within a specified time. For example, access to primary health care should be defined in terms of cost and travel time to the nearest point of service.

Helmut Schwarzbach/Still Pictures

The supervision machinery for social and economic rights should be placed on an equal footing with that for political and civil rights. Finally, affected individuals and groups should be given the right to bring complaints against their governments for infringement of the three social rights treaties (ICESCR, CEDAW and CRC), as they already can with the ICCPR.

To monitor the progress of quality of life rights at national level, each country should prepare a National Social Development Plan. This would parallel the National Social Development Strategies prepared under Agenda 21. It would specify minimum levels of basic needs such as health or education, and set targets and deadlines by which they should be reached. Key indicators should be developed for social and environmental trends, and regularly published so that progress can be monitored by civil society as well as by government.

Left : Educating girls in Eritrea and boys in Kenya
This page: Bombay slums and street child in Rio

TVE

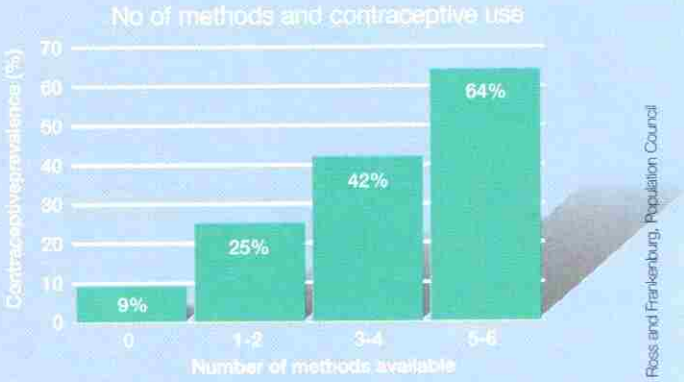
Reproductive health

The Cairo International Conference on Population and Development synthesized a fresh vision on population, especially with the concept of reproductive rights.

The Commission explored some of Cairo's implications further. Reproductive rights covers a lengthy list of components, and the machinery for delivering them to everyone has not yet been designed. If the full list has to be provided in an "all or nothing" approach, then cost will slow down the spread of safe motherhood or of family planning, and many rural areas will remain without services for a long time.

For this reason the Commission advocates a new model: Primary Reproductive Health Care. This should be developed by the United Nations Population Fund (UNFPA), in co-operation with WHO, UNICEF and UNIFEM. Like its sister, primary health care, the model would define a basic minimum package of reproductive services to be made affordable and accessible to everyone.

It would not try to provide all aspects of care at all levels. At village or neighbourhood level it would provide safe motherhood and a basic choice of user-controlled family planning methods, together with basic prevention of sexually transmitted diseases and infertility. Longer-acting contraceptives and treatment of sexually transmitted diseases and complications of pregnancy would be referred to higher levels. Greater choice of family planning methods is a precondition of programme success The Commission takes a clear stand against coercion of any kind in the reproductive health sphere. It opposes numerical targets for family planning recruits, and incentives or promotion for health workers who achieve them. The Commission also clearly endorses the legalization of abortion, except where it is used to choose a child's gender.



Ross and Frankenburg, Population Council

Women's development

Population policy is not just a matter of reproductive rights - it involves every aspect of development that influences family size, including health, education and women's status.

On the health front the Commission notes that the primary health care revolution is not complete. Urban areas and big high-tech hospitals still get the lion's share of resources and of aid, while rural areas are often neglected or palmed off with inferior services. These priorities must be reversed.

On education, the Commission urges a high priority for equalizing male and female enrolment rates at all levels.

Universal compulsory primary education was recognized as an international human right in the ICESCR, which was adopted in 1966. Yet in many poor countries it still far from a reality. The Commission proposes that the United Nations should declare the years 2001-2010 as the Decade of Universal Basic Education.

The aim should be to provide at least six years of free primary education for all. Adults should have access, within one hour's travel, to basic education covering literacy and numeracy, plus the essentials of health and nutrition, child-rearing, community organization and environmental care.

Structural adjustment programmes, which have so often led to cuts in spending on health and education, should *require* that spending in these critical areas should be maintained.

Environment

Though it accepts the impact of population growth on environment, the Commission challenges the idea that anyone can calculate the *population* carrying capacity of the world or any given country. This is because our impact also depends on levels of consumption and of technology, and these can vary widely.

Instead, carrying capacity is redefined as the maximum sustainable load of pollution or resource demand that humankind can impose on the environment before it loses the capacity to support human activity.

On technology, the Commission says that the transition from fossil to renewable energy sources must be speeded up. At present, in view of their uncosted environmental impact, fossil fuels are simply too cheap to use. The relative cost of renewable energies must be brought down as a matter of urgency. Yet spending on renewable energy research in OECD countries was cut by 40 per cent between 1982 and 1993.

The Commission urges that the level of funding for renewable energy research should be steeply increased. It also proposes a 'Manhattan project' for renewable energy. A high-powered international network of laboratories should be set up, with the best workers in each field, to work on bottlenecks and breakthroughs in renewable energy technologies. The technologies which the centres develop would be made freely available to developing countries.

On the agriculture front, soil and water conservation has traditionally been treated separately from increasing agricultural production - and the two have sometimes been in conflict. The Commission recommends that the gap should be bridged in a "greening of the Green Revolution." Production and conservation should be improved in parallel, seeking out new production methods that also conserve soil and water, and new conservation practices that also boost production. ■

Annual Resource Requirements of some global priority programmes

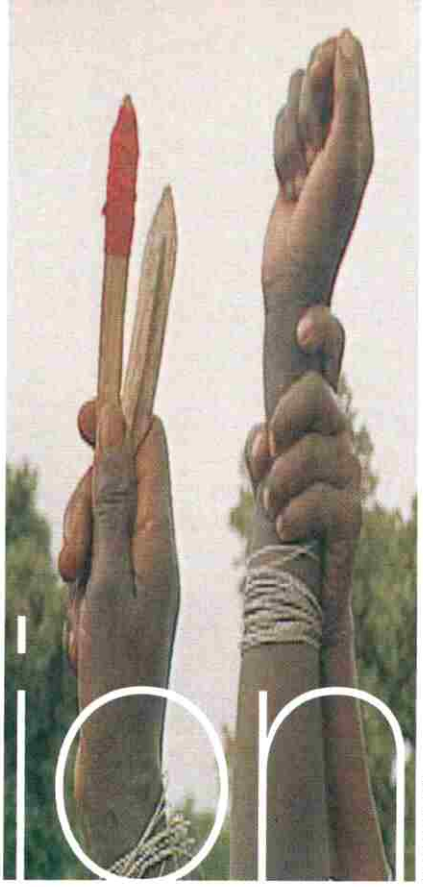
Purpose	Conference	Cost
Primary education for all	World Conference on Education for all 1990	$5-$6 billion
Primary health care Reduction of under-five mortality	World Summit for Children (WSC) 1990	$5-$7 billion
Water and sanitation for all	WSC	$10-$15 billion
Population	International Conference on population and Development 1994	$5.7 billion
Sustainable development	UN Conference on Environment and Development (UNCED) 1992	$80 billion
Combating Poverty	UNCED	$15 billion
Shelter	UNCED	$25 billion

Paul Harrison is author of *Inside The Third World*, and in 1994-95 was editor-in-chief for the Independent Commission on Population and Quality of Life. He is a Contributing Editor of *People & the Planet*.

The Commission's report *Caring for the Future*, is published by Oxford University Press at £7.99. French, German and Turkish editions are in preparation. For further information contact the Independent Commission on Population and Quality of Life, 1, Rue Miollis, 75732, Paris Cedex 15, France. Tel: (+33 1) 40 46 0079, Fax: (+33 1) 45 66 0263.

One of the results of the Cairo Conference was to give fresh impetus to efforts to eliminate the practice of female genital mutilation (FGM), which affects over 90 million women throughout the world, including 22 African countries. Egypt has banned the practice in state hospitals and efforts to change long-standing practices are beginning to show results in other countries. Here **Isabel Mbugua** reports from Kenya.

Ending the mutilation



Charlotte Metcalf

Fifty per cent of Kenyan women have undergone circumcision. In some areas of Meru, Kisii, Narok and Samburu districts, this percentage is as high as 95 per cent. A study by Maendeleo ya Wanawake, a Kenyan national women's organization, indicates that 90 per cent of the women were circumcised and close to 50 per cent were operated on when they were aged between 10 and 15 years.

Whereas female circumcision is today discussed at international and national forums as a violation of human rights, as oppressive and inhuman, and as inimical to female reproductive health, to a considerable number of people in the communities where it is practised, the argument for its continuation is that the practice is a traditional cultural rite of passage.

Yet it is by virtue of it being a rite of passage that circumcision results in most harm. It passes off young girls into adulthood and often into marriage when they are psychologically and physically not ready for it.

"Circumcision of girls makes them feel grown up, and they have no qualms having sexual relations with adult men, and grown men also view them as mature women, ready for sexual relationships. Our studies have shown that in those areas where girls are circumcised there are higher rates of teenage pregnancy and school drop outs. In interviews with teachers in these areas we learnt that there is a noticeable drop in school performance soon after circumcision," says Charity Mailutha, Programme Officer, at the Family Planning Association of Kenya (FPAK), with a special interest in female circumcision.

A majority of Kenyans will agree that female circumcision is no longer a necessity, that it greatly affects the status and development of girls and women, that it is a reproductive and human rights issue. But it is still a cultural practice that some communities are not ready to abandon.

In 1983, when President Moi placed a ban on the practice, Samburu elders, in obvious open defiance, issued a statement that female circumcision is a cultural prerogative of the tribe, and the President had no business telling them to stop it. Indeed when the head of state visited the district soon after, he did not, at least not publicly, bring up the issue.

It is with this understanding of the sensitive nature of the topic that Maendeleo, FPAK and PATH (Programme for Appropriate Technology in Health) have gone out of their way, first to study its prevalence in the districts where circumcision is still practised, establish reasons for its persistence, identify families who no longer practice circumcision and to learn from them.

Using their research findings and employing participatory strategies, these organizations have undertaken community education and information activities to ensure that individuals at the community level appreciate why circumcision must be discarded.

All three organizations consciously chose to use the term female circumcision, and not female genital mutilation.

"The term female genital mutilation connotes malice. But when you talk to even those families who still practise

Betty Press/Panos Pictures

Top: Using theatre to illustrate the problems of circumcision
Below: Reading a Mali news feature on female circumcision

female circumcision, no one intentionally wants to harm their daughters. We use the words female circumcision to avoid antagonizing people and because it is the term most people understand anyway," explains Joyce Ikiara, Assistant Progamme Officer at Maendeleo.

Charity Mailutha agrees with this approach, pointing out that the overall goal of FPAK activities is gender equity, "focusing on the eradication of harmful traditional practices that affect women's sexual and reproductive health rights."

To Charity, female circumcision is a factor that greatly affects the status of women.

"Circumcision has considerable health and social consequences early marriage, school drop-outs and teenage pregnancy are major stumbling blocks to the development of girls and women."

Both Charity and Joyce see the practice as a community issue. In all the communities where the practice persists, bride price, is deeply entrenched.

"An uncircumcised girl fetches a lower bride price, and therefore a girl who refuses to be circumcised is a threat to the would-be wealth her father expects on her marriage. We know of cases where girls have been ostracized by their parents for refusing to be circumcised," says Charity, giving the example of a secondary school student whose parents refused to have anything to do with her when she chose not to be circumcised.

Even though 71 per cent of girls interviewed during the FPAK study said other people had made decisions for them, Joyce feels strongly that girls should be targeted with information about the practice, and given the confidence say "no".

An uncircumcised girl is likely to be taunted by her family, friends, school mates and young boys. But when armed with information and some formal education she can withstand the pressure. Indeed only 62 per cent of girls with secondary education were circumcised, compared to 96 per cent of those with no education.

One of the arguments for female circumcision is that it prepares girls for responsible married life. Girls who are not circumcised, it is argued, are immoral, make rude wives, and daughters-in-law. In some communities it is drummed into the girls' head right from a tender age that no man will marry an uncircumcised girl. Faced with such beliefs, both FPAK and Maendeleo and PATH saw the need for sustained community-based education.

Starting with opinion leaders, health workers, teachers, men women and children are all given information during seminars, public meetings and through specially selected and trained village level 'gender educators'. Health learning materials had also been produced, printed and distributed in the project areas. But after giving all this information, and helping some people change, an alternative had to be designed.

Says Samson Radeny of PATH: "We discussed at length with the community what they felt would be a suitable alternative, especially in those communities where the practice did not necessarily lead to marriage."

When girls are circumcised, they go into seclusion. Each girl has the equivalent of a godmother, who holds her during the operation, takes care of her to make sure she heals properly. It is these 'godmothers' who teach the girls what it means to be an adult, especially in marriage.

At the end of the seclusion period which could be seven days for school going girl's or two months for those who are to be married off soon after, there is a colourful community celebration, with a lot of feasting and dancing, and the girls are showered with gifts by their parents and relatives.

PATH, Maendeleo and FPAK have all promoted this alternative ceremony which allows the community and the girls to go through all the steps except the actual operation. In addition some family life education skills have been imparted to the 'godmothers' so that the girls are well armed to face the challenges of adolescence.

"We make sure the information they receive during the seclusion period includes how their bodies work, relationships, responsible sexual behaviour, conception and other life skills," explains Joyce.

This alternative ceremony has been accepted in some areas but not in others. So is the battle being won?

For Charity Mailutha, the changes are significant. "Female circumcision was not a subject people talked about. Even when you got women only in a group it took a long time to make them talk. But villagers in Meru easily discuss the merits and demerits of the practice. Equally impressive is the number of former circumcisers who have denounced their profession and are now strong community educators.

Egypt breaks with tradition

The International Planned Parenthood Federation (IPPF) has reacted strongly to an attempt by a group of Egyptian doctors to challenge in the courts an order banning female genital mutilation in state hospitals, issued last year by Dr Ismail Sallam, the Minister of Health and Population.

The IPPF Secretary General, Ingar Brueggemann, wrote from Mexico to the Egyptian Prime Minister, Dr Kamal El-Ganzouri, with signatures from 47 representatives from the Western Hemisphere Region of the organization, giving strong support to Dr Sallam's action. Other letters of support have gone out from IPPF's London headquarters, attaching the signatures of 100 doctors.

In her letter Ms Brueggemann said: "IPPF is against all types of abuse, particularly mental and physical abuse of women and children, and believes female genital mutilation (FGM) deserves special consideration as it is an assault on the integrity of the person and compromises the health of young infants, adolescents and women on whom it is performed."

"The Federation is also concerned about the violation of medical ethics posed by this practice and the profound health costs to society generated by FGM."

J.H.Morris/Panos Pictures

The latest 1996 Demographic and Health Survey in Egypt reveals that female circumcision is virtually universal among women, with 97 per cent between the ages 15-49 having been circumcised. Among survey respondents with one or more living daughters, 87 per cent report that at least one daughter has already been circumcised or that they intend to have the daughter circumcised in the future. The median age at circumcision is 9.8 years of age.

Most circumcision takes place at home. Increasingly, circumcisions on girls are being performed by doctors. Even so, women report that about one-third of circumcisions on their daughters were performed by *dayas* (traditional birth attendants). Among the possible side effects of these medically unnecessary procedures are haemorrhage, shock, infection and death.

The results suggest that abolishing this practice will be challenging. More that 80 per cent of women support the continuation of circumcision. Seventy-four per cent believe that husbands prefer circumcised women and 72 per cent erroneously believe circumcision is a religious tradition. Relatively few women recognize the negative consequences of circumcision, such as reduced sexual satisfaction (29 per cent), possible death (24 per cent), and higher risk of problems in childbirth (5 per cent).

Changing ways in Uganda

Kapchorwa, a tiny town in the remote mountains of eastern Uganda, is the unlikely setting for a remarkable success story in the struggle to change traditional attitudes to the circumcision of young girls, *writes Charlotte Metcalf.*

Charlotte Metcalf

The town is the home of the Sabiny people. Isolated by geography, poverty and lack of industry, they are fiercely protective of their culture. They are the only people in Uganda to circumcise the women.

Efforts in 1992 to shock the authorities into outlawing the practice through the production by a woman doctor of a gory film of mass circumcision of the girls, rebounded. The local people were outraged by the way their local culture was portrayed as being barbaric and backward. When the film was aired for a second time in 1994, twice as many girls as in 1992 opted for circumcision, a signal of their proud resistance to outside interference.

Now, just two years later, there is a radical change. Not only have the Sabiny girls chosen to reject the practice, but their right to choose has been sanctioned by the Clan Elders.

This astonishing turnaround has been brought about by a programme known as REACH (Reproductive and Community Health), the brainchild of the country representative of the UN Population Fund (UNFPA), Dr Francois Farah.

A charming and cosmopolitan Lebanese-born Canadian, he began by mastering the rudiments of the difficult language of the people. Then in a respectful and non-judgmental way he encouraged the Sabiny people to be proud of their culture while questioning the legitimacy of some of its practices. This approach accepts that a ritual which marks a girl's passage into womanhood is culturally valid and should be enhanced – with celebrating, dancing, singing and gifts to symbolise the coming of age. But it rejects circumcision itself, which serves no useful purpose.

The programme offers extensive education about the dangers of female circumcision – with a stress on 'offers'. It neither prescribes nor rebukes about genital mutilation. In fact, rather than use the that phrase with its implicit criticism, Farah prefers the plain and accurate 'genital cutting'.

He points out the many harmful effects of genital cutting. They include excessive bleeding, urine retention or incontinence, infections, the risk of HIV from dirty blades and the formation of scar tissue which can make birth difficult or even impossible. Girls have been known to bleed to death or die during births complicated by the operation. In addition there is the severe debilitating pain and psychological trauma.

However, even clinical arguments are hard to stand up in an environment in which people believe an uncircumcised woman is not fit to gather grain from a granary, let alone be married. It was against the backdrop that REACH went to work.

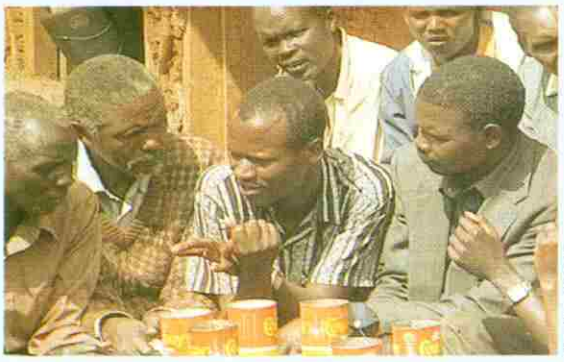
Jackson Chekwoke (below) is the REACH project manager. He watched his sister nearly bleed to death because she was circumcised when pregnant. His mother-in-law (left) is paralysed in both legs as a result of circumcision 20 years ago. Jackson knows that men are the key to change in a male-dominated society, and he spends hours among fathers, brothers and decision makers, telling them of the dangers to their sisters, daughters and their wives - and how the practice can inhibit the healthy birth of potential sons.

REACH has also armed the teenage girls with significant facts and sends them into their schools to spread the message. I listened as two sisters aged 17 and 18, spoke out passionately about their views of adulthood. They both insisted they would only become women when their education was complete. In their eyes genital cutting had nothing to do with achieving maturity. They told me in whispers of two friends of theirs who had been forced by their parents: their legs were tied open and men sat on their chests to hold them down. Because they were struggling, the clitoris was cut savagely and messily. One of the girls is now incontinent.

Meanwhile Farah has worked tirelessly to sway the Elders. Mr Cheborion, Chairman of the Elders, admits he once supported the practice but now sees it as abhorrent. "It is essential we modernize and that our culture is not left behind," he says. "Education is the answer. The less ignorant we are, the more this practice will die out."

In fact, it was expected that virtually no girls in the community would choose to undergo the knife at last year's end. But as Farah points out, this is only a pilot project. The practice of genital cutting affects the lives and unborn babies of 90 million women. "This is only a start" he says. "Let's not forget the women all over the world who continue to suffer this futile and dangerous practice."

Charlotte Metcalf is an English film producer, who recently visited Uganda to make a film about the REACH programme *(See page 31).*



Charlotte Metcalf

"Another indicator of success is the number of girls who write to us asking for assistance because they have decided, against family pressure, not to undergo the operation."

The issue is a public debate now, even among school children.Women's groups have composed songs and skits against it, and role models publicly declare they are not circumcised. Health workers discuss it with patients, and chiefs call *barazas* (public meetings) to discuss circumcision as a development issue.

"Among young men, use of slang terminology is an indication of changed attitudes. An uncircumcised girl is referred to as a *Manyanga* or *Mambo Yote* (*manyanga* is Swahili slang for young, new, while a lose translation of *mambo yote* would be 'she is everything'. A circumcised girl on the other hand is nicknamed *mitumba* (second hand, or used). Even in churches preachers are talking about female circumcision during baptism, and this is very encouraging," says Charity.

FPAK, Maendeleo and PATH see light at the end of the tunnel as far as discouraging circumcision goes. They realize it will take long in some communities, but with sustained community based education and mobilization, change will come about.

"The more girls get educated the more they will be in a position to make their own choices." ■

● *A motion seeking to ban female circumcision was defeated in the Kenyan parliament on November 13, 1996.*

Isabel Mgubua is a Kenyan journalist who specialises in development issues.

A partnership

Brazil's response to the Cairo Conference on Population and Development has been to create a National Commission on the topic, advised and monitored by women activists. **Cristina Cavalcanti** reports from Rio on the Commission's progress and the problems that remain.

As the sixth largest country on earth, with a largely urban population of over 160 million, projected to grow to some 230 million by the year 2025, rich in resources and a Pandora's box of social and environmental problems, the formation in Brazil of a National Commission on Population and Development to follow through on the Cairo recommendations has roused a good deal of interest - not all of it sceptical.

The Commission includes experts from all the Ministries and eight members from civil and academic institutions. Suprisingly, it is not headed by a political figure or a civil servant but by a feminist demographer, Elza Berquo, who is able to draw on the experience of previous efforts to mobilise public concern over the issues of population, reproductive health and women's rights.

The first of these was a short-lived Commission for the Study of Human Reproductive Rights in the 1980s. This was followed by the creation of a National Women's Rights Council, which succeeded in establishing the principle of State provision of family planning services within the health sector, and a week's holiday with pay for father's after the birth of a child. Both were included in the Republic's Constitution in 1988.

Mark Edwards/Still Pictures

Left: Brazil, one of an increasing number of teen -age mothers unable to finish their schooling

Right: Mother and child, Brazil

The aim of the new Commission is to analyse the likely demographic impact of public and private policies and initiatives, especially in the fields of education, health and women's rights, and to assess their effect on the quality of life. The Commission also plans to promote teaching and training on population and development matters.

To help in this, it has begun to study the data bases of all the Ministries, looking for common ground on which to base development indicators. It has also worked with the Ministry of Education to prepare teaching materials for schools on population issues. These include text books on education for citizenship and on sex education.

Perhaps inevitably, these latter aroused strong objections from the Catholic Church. In the debate which followed, the Ministry of Education pointed out that 11,000 babies had been born in 1994 to girls under 15 years old, and that a fifth of all women giving birth that year were adolescents. In fact, Elza Berquo stresses how much more needs to be done to improve health education among young people.

A survey in 1995, published by the Health Secretary of the City of Rio de Janeiro, highlighted the close relation between education and early pregnancy. This showed that 65 per cent of adolescent mothers between 15 and 19 were still in the first grade or had been forced to leave before finishing their schooling (the first grade in Brazil normally takes children up to 14 or 15, but sometimes older), 19 per cent had completed first grade and only eight per cent were in secondary school. According to Dr Berquo, the Catholic Church has agreed to reconsider its objections after facing the facts.

Even though teenage pregnancy is rising the total fertility rate (TFR), which measures a woman's completed family size, has decreased from 5.6 children in 1970 to 2.5 in 1996. Dr Berquo sees no reason why this trend should not continue and points out that among some sections of the population birth rates are already below replacement level. About 70 per cent of women are practising contraception, but the use of oral contraception has dropped from 25 to 21 per cent of all users according to the 1996 National Demographic and Health Survey, and there is very extensive reliance on sterilization.

Brazil has thus arrived at fertility rates close to those of the First World, but with contraceptive methods typical of parts of the Third World. Surveys show that 57 per cent of married women - or 40 per cent of all women of reproductive age - have been sterilized. Six per cent of these have only one child. Even more surprising, the average age of sterilized women is only 29.

This concentration on sterilization is related in Brazil to the widespread use of caesarean operations by the medical profession, who earn more from this than from normal births. According to research by the University of Campinas, about 400,000 caesarean sections were performed in 1991. These are either sought by women as a way to obtain sterilization (which is in something of a legal limbo), or are decided upon by some unscrupulous doctors and private hospitals who bill either the woman or the state for the procedure. Research indicates that about three-quarters of all women sterilized have had the operation at the same time as a caesarean birth.

Maternal death rates, meanwhile, remain high. One woman in Brazil dies every four hours from obstetric complications at birth. Mortality rates at 100 per 100,000 births are well below the South American average, and pre-natal care has improved, but the figure remains much worse than developed country rates of between 5 and 30 per 100,000. The main causes of death are toxaemia, haemorrhage, infections and illegal abortion - of which there are about 1.4 million a year, a third of them leading to hospital admission.

A 1940 law authorises abortions when pregnancy results from rape or puts the life of the mother at risk. Even so, only the cities of Sao Paulo, Campinas, Rio de Janeiro and Brasilia provide legal abortions at public hospitals. Soon, the cities of Goiania and Porto Alegre will also provide abortion services under municipal law, thanks to pressure from doctors, women's groups and city deputies.

Commenting on this situation, in an interview with *People & the Planet*, Elza Berquo said that "a concentrated effort is needed to overcome the inertia that characterises the bureaucracy, particularly in the Ministry of Health and which has failed to implement the Women's Integrated Health Care Programme (PAISM)." This important landmark in the struggle for reproductive

for women

well-being, was created in 1983 as a result of a joint effort by the women's movement and the Ministry of Health. Going beyond reproduction, it looks at women as workers and citizens and offers to support them throughout their life cycle. The aim is to give women enough knowledge to gain control over their health.

Ideally it would provide all women with integrated clinical and gynaecological care and education for health from adolescence through old age. As well as obstetric care, it would help in the control and prevention of sexually transmitted diseases and cancer, provide contraceptive services and assistance during menopause. The main banner of the women's movement, PAISM has been put into practice by the public health system of very few cities and states.

In a country where 75 per cent of the people have no access to private health insurance and where the average expenditure on health has gone down from US$80 in 1989 to US$48 in 1993, that a programme like PAISM would bring big savings to the health budget while improving the health of women and children.

Another leading feminist, Mary Castro, a sociologist who acts as advisor to NCPD, believes that the Commission has established the principles for action up the year 2000. She says the Commission will guide the negotiations between the Government and the UN Population Fund and that UNFPA should be able to provide very useful research, training and operational support.

The Commission will also be able to draw upon the work of the National Feminist Reproductive Health and Rights Network, made up of 100 women's groups and individuals, who will try to measure progress in carrying through the Cairo Plan of Action in Brazil. Two issues will be watched with special care in nine states: the introduction and functioning of legal abortion services and the participation of women in the city and state councils and commissions that deal with women's reproductive health.

Their findings will be promoted in debates, seminars and publications. Their hope is that enough social pressure can be brought to bear on those with power, that the agreements signed in the conferences of the 1990s can begin to improve the quality of life for everybody. ■

Cristina Cavalcanti is an anthropologist and freelance journalist, and *People & the Planet* correspondent in Brazil.

Mark Edwards/Still Pictures

Two years after the Cairo Conference a tentative start has been made in South Africa on one of its key goals - improving women's health, including their access to reproductive health services. **Caroline Wheal** reports from Johannesburg on the long struggle that lies ahead.

Eric Miller/Panos Pictures

A long road to women's health

Separate toilets and beaches for whites and blacks may have disappeared with the dismantling of Apartheid but health care in South Africa is still, for the most part, segregated along racial lines.

Blacks in the urban areas have access to the oversubscribed, chronically understaffed government hospitals; whites and an emerging black middle class generally pay escalating medical aid premiums that allow them to use private clinics. Rural blacks, if they're lucky, may have a small clinic within walking distance, or a mobile unit that passes their village once a week or so.

Black women - especially poor, rural black women - are South Africa's most disenfranchised group. They lack social and political status, thanks to a cultural tradition that has entrenched their subordination to men; they tend to be employed in badly paid jobs with little legal protection as domestics or agricultural labourers; years of crisis in black education have contributed to high illiteracy; and the amount of time needed to collect water, gather ever-scarcer fuelwood and keep the household together (women's work) often means chronic, debilitating overwork.

Coupled with malnutrition and contaminated water, life for these women is difficult and definitely not conducive to healthy well-being.

Marion Stevens, a policy analyst for the Women's Health Project in Johannesburg, admits there has been 'no change' in the general status of women's health since the change of government in April 1994. "Implementing reproductive health services is just not seen as a priority," she says, with the half-angry, half-determined look of someone used to battling the Goliath of government.

However, since the Project began in 1991 - with the goals of educating women about their bodies and effecting policy changes to better women's health - it has lobbied successfully for routine cervical cancer screenings to be performed at government clinics three times in a women's life (at 35, 40 and 45). The next hurdle is communicating the importance of a Pap smear to women in whose language there is no word for "cervical cancer" - the most common cancer among South African Women.

Groups like the Women's Health Project seem to be up against insurmountable odds: women scattered over wide rural areas; the communication barrier caused by South Africa's 11 official languages; the African male attitude towards women 'interfering' with fertility; and a government whose efforts and limited resources are more often focused on providing the bare essentials, such as water, housing and jobs, to its people.

Gisele Wulfsohn/Panos Pictures

Top: Mobile health clinic, Southern Cape

Above: Rural village near Johannesburg

Right: Women in townships have poor access to health services

Present clinic services in most of the country are regimented and vertical. That is, if you have a sexually transmitted disease (STD), you go to one place on a certain day; another place on another day for antenatal care, and so on. Opening hours are short; waiting times long; and the often judgemental. The frequently unsympathetic attitudes of health workers, particularly towards teenagers trying to get contraceptives, do not encourage patients to return.

There is widespread frustration with this top-down management and the splintered hodgepodge of local and provincial clinics that duplicate some services and leave others - particularly counselling and education - untouched. At many government-run family-planning clinics, for example, Depo-Provera remains the most widely dispensed contraceptive - not necessarily because more women choose it but because it's often the only one being offered. Although the quarterly injection has the benefit of allowing women to prevent pregnancy more surreptitiously than most methods (thereby avoiding confrontations with a husband who feels his virility is on the line), it does not address the problem of STDs. Some women's groups also worry that dispensing contraceptives without proper counselling and follow-up perpetuates the attitude that population control is still the driving force behind the service.

"It's all very well for Mandela to announce 'free health care for pregnant women' and another to see it happen," says Stevens referring to the President's 1994 declaration. The sequel to that - free primary health care for all South Africans - was announced by Health Minister Nkosazana Zuma in March 1996. The

idea is to try to get people to use clinics, not stressed hospital outpatient departments, as their point of entry into the public health system. It's an ambitious plan that will take an estimated eight years to achieve and cost R5.31 billion (US$ 1.16 billion) in the first year. The problem is that existing primary health care facilities just aren't ready to take the load.

Although the province of Gauteng, which takes in both Johannesburg and Pretoria and has a population estimated unofficially of 10 million has 305 clinics on paper, most are diagnostic centres only. A mere 40 of them are curative and can treat that STD rather than simply telling you you've got it. More than R20 million (US$ 4 million) was spent in 1995/96 on building and equipping 7 new maternity/obstetric units and 22 clinics. A further R100 million (US$ 22 million) has been budgeted for 1996/97 upgrades.

With funding from the UN Population Fund (UNFPA), a pilot project began in January 1996 in three regions to transform existing clinics into more holistic health care centres that will deal with everything from dispensing contraceptives and screening for hypertension to counselling on domestic violence - a serious problem in South Africa.

As shown by the drawn-out wrangling in Cairo, the most controversial aspect of any comprehensive reproductive health system is safe, legal abortion. Last September, a bill to allow abortion on request up to 12 weeks (and beyond under more restrictive conditions) was tabled in parliament. If passed, the bill will overturn the existing law that allows abortion only in cases of rape, incest and when the mother's physical or mental health is in jeopardy.

But it's a big problem "if." With doctors already in some areas already vowing never to perform the operation, religious groups threatening to oppose it in the constitutional court, and a national poll showing only 23 per cent of 3300 respondents in favour, the Termination of Pregnancy Bill looks set to become as acrimonious a battleground for so-called pro-choice and pro-life advocates as it is in the United States. With one major exception: in the United States, abortion on demand is already legal. In South Africa, it hasn't been since 1975, when the National Party, concerned about high rates of abortion among white women, outlawed it.

At the moment, obtaining a legal abortion requires money, time and knowledge of a convoluted system. Because of that, fewer than half of abortion applications are successful. Of the 1000 legal abortions in 1993, most were for white women, and three-quarters were performed on psychiatric grounds, requiring a doctor's referral to two psychiatrists. A women who wants legal abortion following a rape is required to have filed a police report at the time, often at a small-town police station staffed mostly by men.

Having an illegal abortion isn't difficult. Between 200,000 and 300,000 are performed each year. With money and connections, a woman can pay a sympathetic doctor and take a quiet day off work; if not, and she's desperate enough, she resorts to the potent herbal cocktails, bamboo shoots, coat hangers and catheters used by rural or 'back-street' abortionists.

According to a Medical Research Council study, almost 45,000 women - only one per cent of them white - were admitted to hospitals last year with incomplete abortions. Of those, 425 died of the complications. Given the fact that many women would be too afraid to go to hospital or too far away, it's safe to assume that the actual numbers are much, much higher. Like health care in general, then, abortion in South Africa is a racial/economic issue. Poor black women are taking enormous risks and dying; white women are not. This factor alone puts the ANC, 75 per cent of whose members are against liberalizing abortion, in an awkward position.

The overall health of South African women will not improve until their social status increases through the provision of water, shelter, energy and hygienic sewage and refuse removal; economic independence; education; and access to health and education services. The option of safe and legal abortion is very definitely a part of the latter and women's health will continue to be compromised until 1975's legislation is overturned. Perhaps those parliamentarians who have the power to change the law should try to think of it not so much as a vote "for" abortion, but rather for a woman's chance to control her body. ■

● *South Africa's new, liberal, abortion law has now been passed by the National Assembly. It was signed by President Nelson Mandela in December.*

Caroline Wheal is a freelance journalist based in South Africa and a former staff writer with the Cousteau Society.

Chris Sattlberger/Panos Pictures

Jean-Leo Dugast/Panos Pictures

When So

One of the outcomes of the 1994 Cairo Conference was the setting up of a new organization to promote South-South collaboration: Partners in Population and Development. Here **Deirdre Wulf** outlines the thinking behind this initiative and **Ajoa Yeboah-Afari** reports on one of the first partner projects, linking Bangladesh and Ghana.

The idea of swapping technical know-how in reproductive health and family planning between countries of the South is not new. Last summer, five senior journalists saw for themselves how this can work in the Red River Delta region of northern Vietnam.

They spent a day in rural Ha Tay province learning how community mapping was being used by volunteer workers to keep track of contraceptive use in the community - an idea first developed in Indonesia and now transferred to Vietnam with French funding and the help of BKKBN, the Indonesian national family planning co-ordinating board.

The also spent time in the rice fields of Ninh Binh province, looking at an income generating project operating as part of the reproductive health programme in the area. The project was being carried out with the help of a Bangkok-based NGO, known as PDA, and Australian funding.

One of the journalists, from Germany, commented on what he had seen by saying: "It's clear the Partners want to exchange their hard won experience to help one another."

Now this approach will be given more visible life, with planned co-operation and careful monitoring and assessment by the 10 partner members: Colombia, Egypt, Kenya, Indonesia, Mexico, Morocco, Thailand, Tunisia and Zimbabwe.

All 10 countries are recognized for the effectiveness of their national family planning programmes, and for their success in reducing unwanted childbearing and in improving reproductive health conditions. The Partners, from each country, are made up of the highest-ranking government officials responsible for the national family planning programme in each country. In September 1996, a permanent secretariat for the Partners in Population and Development opened in Dhaka, Bangladesh. An executive committee will meet twice a year.

The Dhaka secretariat is deliberately being kept small (for the time being staffed only by an executive director and three deputies - all from developing countries), and will operate as a clearing house and co-ordinating body, not as an implementing or funding agency. In fact, the secretariat will not have funds of its own to dispose of. Rather, it will search out worthwhile projects, match up countries whose technical assistance needs and areas of expertise coincide, field requests for assistance from non-Partner countries, and advise on and help identify the most likely sources of donor support. For the first two years of operations, the modest administrative costs of the Secretariat will be covered by funding provided by the United Nations Population Fund, the World Bank and the Rockefeller Foundation.

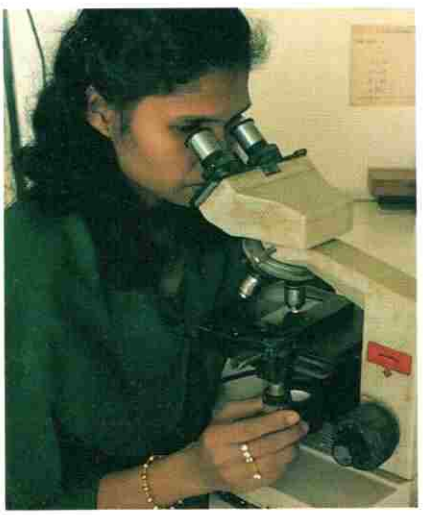
Why do these donors believe that the Partnership is a good idea? First, because exclusively north-south technical assistance in population affairs has always run the risk of appearing to reflect a form of demographic imperialism. But concern about rapid rates of population growth is now as pronounced among the leaders of the South as it is in the North. That awareness now also includes sharp concerns about high levels of maternal mortality, unsafe abortion, the spread of often deadly sexually transmitted diseases, and continued patterns of discrimination against women. And the northern countries are no longer - if they ever were - the sole repository of all wisdom and technical know-how in these expanding fields of human rights and reproductive health.

Above all, South-South co-operation makes good financial and political sense. For the first 30 years or so of family planning programmes in Latin America, Asia and Africa, technical assistance did not come cheaply: most programme advisors were recruited from universities, research organizations, and health agencies based in Geneva, Paris, London, New York or Washington; and, most professional training was given in western institutions. Today, many leading experts in population and development are from developing countries, and there are now excellent training centres in every region. These institutions have the capacity to meet every conceivable need that might exist, whether for training in the formulation of national policies, in the insertion of IUDs, or in advanced management information or contraceptive commodities systems.

But the concept goes far beyond simple training activities. Collaborative projects will be rigorously assessed in terms of their usefulness to the country in question and their long-term sustainability, once technical assistance and outside

Top: Women working in paddy fields, Vietnam

Below: Thailand's expertise with HIV/Aids prevention is useful to all developing countries



Peter Barker/Panos Pictures

uth meets South

funding have ended. Appropriateness, or suitability, and sustainability have not always been important considerations for outside donors. The population projects in Ninh Binh and Ha Tay provinces visited by the western journalists are probably typical of the type of informal, ad hoc activities that have characterised South-South co-operation up until now. Neither the implementing nor the funding agencies involved had the capacity to evaluate the long-term relevance, viability or impact of these projects.

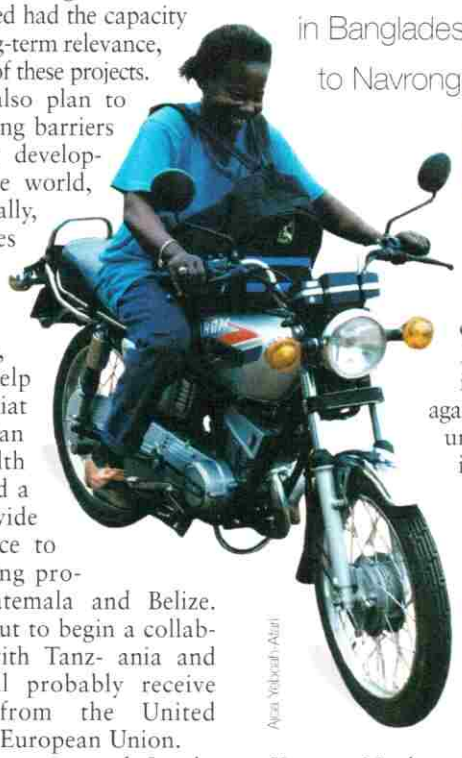
The Partners also plan to break down existing barriers between different developing regions of the world, even though initially, Partner countries are likely to be working with countries close to home. For example, with planning help from the secretariat staff, the Mexican Ministry of Health has just completed a proposal to provide technical assistance to the family planning programmes of Guatemala and Belize. And Kenya is about to begin a collaborative project with Tanz- ania and Uganda that will probably receive joint funding from the United Kingdom and the European Union.

However, the concept of South-South co-operation will eventually transcend regional borders. For example, because of the scale of its own HIV/AIDS problem and because of the creativity and boldness of its policies, Thailand is recognized as having longer and wider experience in prevention and diagnosis than any other developing country in the world. For this reason, northern donors will readily understand the urgent rationale for South-South collaborative HIV/AIDS projects involving Thai medical, epidemiological and communications experts. ■

Deirdre Wulf has been a writer and editor in the population and family planning field for almost 20 years, including many years in the publications division of the Alan Guttmacher Institute, in New York. She now works as a freelance writer and publications consultant.

How Navrongo learnt from Matlab

In one of the first experiments in co-operation by the South-South partners, Ghanaian health administrators are putting into place a community-centred reproductive health system in a remote area of the country, based upon the lessons they have learnt from Matlab in Bangladesh. Our correspondent, Ajoa Yeboah-Afari, travelled to Navrongo in North Ghana to research this report.



Ajoa Yeboah-Afari

Zooming about the countryside on her powerful motorbike, kitted in a crash helmet and trousers in an area known for its conservatism, Gladys Mahama presents an incongruous sight against the back drop of untarred roads and isolated mud houses, dotted in the vast fields of greenery. Although she is not in uniform, the satchel of drugs she carries with her is the clue to her identity.

A community health nurse in the Kassena-Nankane District of the Upper East Region of Ghana, 30-year-old Mahama is symbolic of a health delivery experiment that has the potential to radically change health care arrangements not only in Ghana, but in other developing countries as well. It is giving meaning to the Ghana Ministry of Health's slogan: "Improving quality, improving coverage".

She is one of a group of 16 nurses who are key workers in the Navrongo Community and Family Planning Research Project. Building on the extensive work done in the Matlab District of Bangladesh over the past 30 years, with its emphasis on household family planning and primary healthcare, the aim of the Ghana project is to find the best way of delivering health services alongside family planning.

So successful has this experiment been that some of the lessons learnt are now being transferred back to Matlab, to improve on the work there.

The Navrongo project has shown that Ghana's idea of residential community nurses, which it has previously failed to operate in the past 20 years, can be made to work. The communities involved are enthusiastic and have told Dr Fred Binka, the Project Director, that they believe the new system will do much to solve their health problems.

Previous efforts to meet reproductive health needs and thus reduce the very high fertility rate, which is threatening Ghana's development, have largely failed, says Dr Alex Nazzar, Principle Investigator of the project. Although the country was one of the first to adopt a national family planning policy, the actual use has remained low.

Studies in different parts of the country, notably one in East Regional capital of Bolgatanga, had shown that the priority of the women was not so much how to control or space births, but to make sure that their children survive. With the help of the Rockefeller Foundation it was decided to set up the project at Navrongo, where there was an established research centre, and to try to develop a health delivery system much closer to the people and very

Ajoa Yeboah-Afari

different from the previous bureaucratic top-down one.

In consulting the villagers, it was decided to make use of the traditional durbars often used by politicians to get their messages across, and a system of *zurugelu*, or togetherness was also used to bring researchers and communities together. At the same time, the Navrongo team visited Matlab and were "enthralled" by what they saw, especially by the idea of following a patient's progress over time.

One result of the *zurugelu* was agreement that a nurse based in the local community would best serve local needs and that a pilot project should be started to find out how best to introduce the nurse into he selected group of villages. The chiefs and elders also agreed to select Village Health Volunteers who would help the nurses. A third part of the pilot project was to find out how best the nurses could overcome the virtual taboo on contraception among some people, and how best this service could be made part of the general health system.

Three nurses were appointed to three areas to test various strategies, and it was found that the best one was for the nurse to live on her own in a detached hut where privacy could be assured. The villagers built the huts for the nurses using the traditional system of communal labour and each nurse was supplied with a motorcycle, drugs and contraceptives, for which a token fee is paid.

"The nurses go from compound to compound providing compound-relevant and specific health education" explained Dr Nazzar. Each nurse serves about 3,000 people.

In the traditional North Ghanaian system, each compound has an extended family living together in a set of huts accommodating from two people up to a hundred, and Nurse Mahama's day starts early to cover at least seven compounds before the women leave for their farms or the market. She is on her motorbike at 5.30am and will be on call for most of the next 24 hours, when not visiting homes. Speaking the local language she is able to give family planning advice whenever the women come to her home.

She is convinced that this system encourages many more women to use contraception. "If they have to go to Navrongo for this service, they certainly won't, but now that I come to their door-mouth, there are many more clients. I believe that through this plan most of the women will come to use family planning."

However, there are still many misconceptions to be overcome, she says. Many fear that contraception will make them barren and many men fear that it will encourage the wives to be unfaithful. Still, she says, progress is being made.

Dr Nazzar says the changes have, in fact, been extraordinary. At one time the women would hold back in one corner of the room during durbars. Now they come forward and are very outspoken. "They ask questions. Indeed, they express themselves better than the men." At the start of the micro pilot project, only two women out of 2000 were using contraception. Now the number is 217, most of them opting for the periodic injection. And while some men are against contraception, others are now accompanying their wives to the nurse and others are making appointments for them.

On the health front there has been spectacular rise in child immunisation, to over 85 per cent in some villages, and a corresponding fall in infant and child deaths.

However, not everybody is so enthusiastic. Critics include one medical doctor who questions the costs involved. "What happens when the donor money stops?" he asks. Would the Ghanaian Government be able to replicate this sort of investment throughout the country?

Countering that are those who say

Jorgen Schytte/Still Pictures

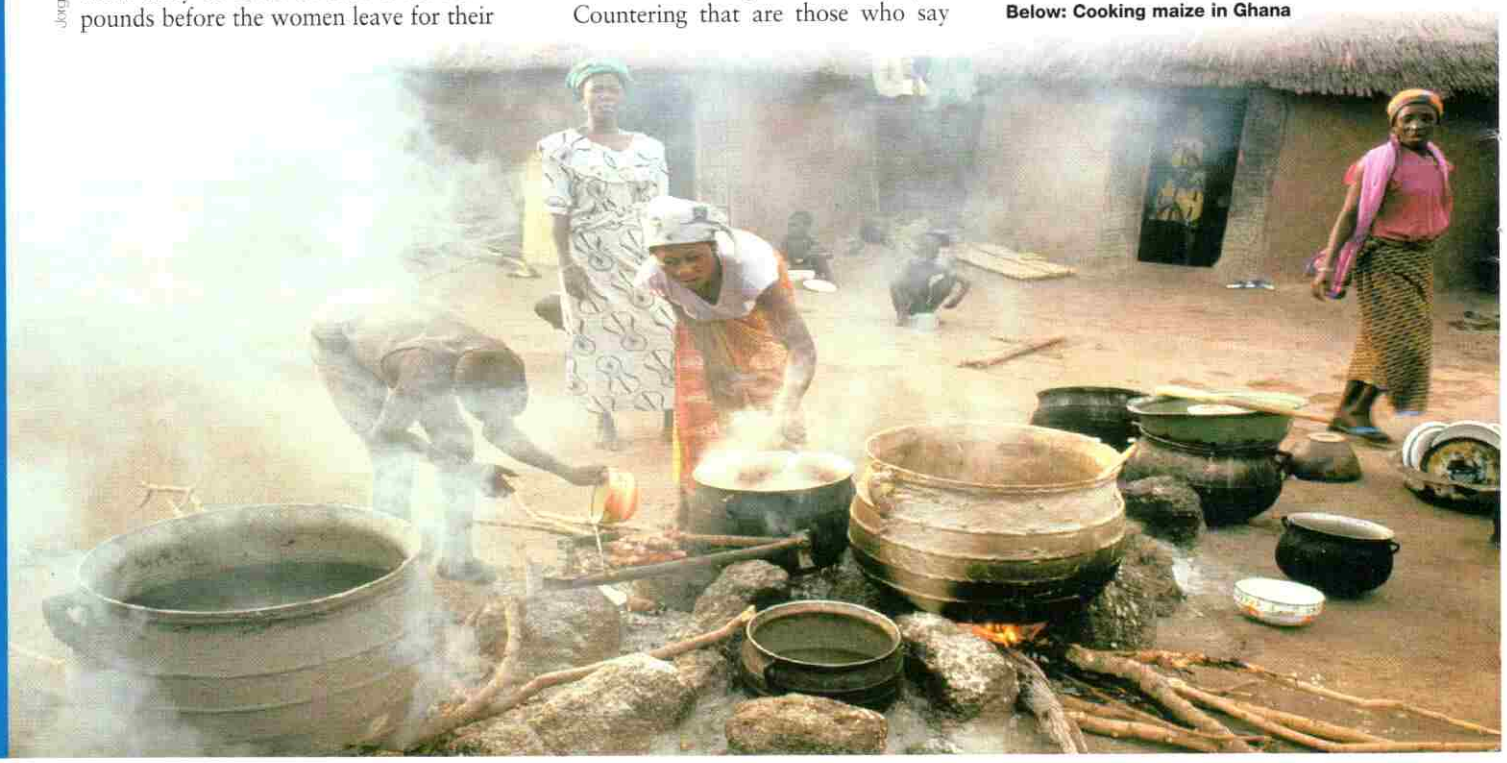
that if Navrongo succeeds in its exciting promise of making contraception acceptable in such a conservative area, while improving child survival and the well-being of mothers, its impact on national development cannot be underrated. It could also result in significant savings in fixed health structures.

If nothing else the project has shown the value of South-South co-operation and of using local traditions to communicate with the people. It has proved the popularity and effectiveness of doorstep health care and the long-term benefits from the assertion of women's rights to make their own reproductive choices. For all these reasons it is on course to achieve the objectives for which it was established.

The Navrongo experiment is already being copied in some other parts of Ghana, and other African countries including The Gambia, Tanzania, Kenya and Uganda, as well as Indonesia, have benefited from computer software developed by the project staff to show how the service is run. ■

Top: Women with babies on their backs carry calabashes to market. They've been walking for four days

Below: Cooking maize in Ghana



Jorgen Schytte/Still Pictures

A 'smashing success'

On 1974 I attended the World Food Conference at the Rome headquarters of the UN Food and Agriculture Organization (FAO). FAO leaders proclaimed time and again that within ten years nobody should be going to bed hungry any more. The response of those experienced in the ways of FAO was "Deliver, then we'll believe it." Ten years later there were more people chronically malnourished - jargon for semi-starving - than ever before. Another ten years on and the situation was worse yet again: a whopping 800 million people underfed, every sixth person in developing countries.

So the world's governments asked FAO to convene a World Food Summit, whereupon agricultural leaders foregathered in Rome last November. The fact that the conference was needed at all implied a continuing duff job on the part of FAO. But instead of making amends, FAO dropped the ball once again, and with even greater panache.

During the months prior to the Summit, FAO produced a mountain of background documents with a decidedly upbeat stance. Yes, we can produce enough extra food within the next 30 years to feed an extra 2.5 billion people. All we need to do is to follow a path of "the same as before, only more so" - that is, set the plant breeders and geneticists to work and produce another Green Revolution. In any case, if we had any doubts about that long-standing approach, what else could we possibly do given that our only guide to the future must be the past? This supposes, of course, that the future will be a simple extension of the past. There is abundant reason to think that won't be so any more, and that we must expect a host of basic departures from former patterns and trends.

First are the mounting problems of the past. Soil erosion, for instance. We have been losing 25 billion tonnes of topsoil per year, a rate fast enough to despatch most of the world's topsoil by mid-way through the next century. By that stage too, we are likely to have used up most of the world's oil. But whereas there are plenty of alternative sources of energy, nobody has devised a substitute for topsoil. If a hectare of farmland is losing 17 tonnes of topsoil per year, that can be enough to reduce crop output by a full one-fifth within 20 years. Yet it amounts to only five millimetres off the soil horizon. What farmer is going to notice that? Hence FAO's response to the erosion problem: what problem?

Just as erosion levies a fearful price for agriculture in the long run, so too do salinization and water logging of irrigation systems. Also, naturally enough (so to speak), advancing deserts, demise of genetic stocks for crop plants, and declining water supplies whether from rivers or aquifers. FAO accorded them hardly a nod as compared with its trumpeting of the next Green Revolution - even though the environmental underpinnings of any revolution need to be safeguarded through an Evergreen Revolution.

FAO further asserted that if there had been any real problems with our capacity to feed our ever-more numerous selves, that would surely have shown up in climbing prices for food. True, prices changed little from 1960 till 1995. But then prices for wheat and maize doubled almost overnight, and that of rice increased by one-third. Still more significant, prices tell only part of the story. The people who suffer the worst food shortages, the poorest people, hardly possess the means to enter the marketplace at all, meaning they are denied the chance of registering their 'dollar preferences' with respect to food. At least 1.3 billion people have a cash income of under $1 per day, and another 1.7 billion people scarcely manage $3 per day. These people amount to over half of humankind, yet they account for well under one-tenth of the global economy. Their poverty causes them to be economically disenfranchised and nutritionally destitute.

Thus arises the profound difference between marketplace demand and actual need for food, the first being only a part (and in some regions and communities, a small part) of the second. So it is strictly inaccurate in economic terms (let alone humanitarian terms) to assert that marketplace prices have much to do with the food purchases of those who most need food of any kind. Yet economist planners at FAO still speak about food prices as if all people enjoy the affluence to eat whatever they want. Anybody with a wallet can order a five-course dinner in Addis Ababa at the height of a famine.

Despite all this, FAO blithely asserted at the World Food Summit that all we need is "continued efforts to maintain and upgrade the world's food production capacity, for example, investment in agricultural research, extension services, increased efficiency in water use, etc." Yet each of these three issues is headed in the wrong direction, as are problems all but omitted from the FAO documents, notably soil erosion, desertification, water shortages and deforestation among other forms of land degradation, plus emergent super-problems such as global warming.

None of this seemed to trouble FAO much. They declared the Summit a smashing success.

Norman Myers is a Fellow of Green College, Oxford, and a contributing editor of *People & the Planet*.

Associates' news

NEGLECTED GIRLS

CEDPA

India's first national conference on improving the life options of adolescent girls was convened by The Centre for Development and Population Activities (CEDPA), the UN Population Fund, and Prerana, an Indian NGO in Delhi, in October. More than 300 representatives of public and private agencies called for immediate national action "to bring about a revolutionary and fundamental change in the lives and potential of adolescent girls." Actions and reforms were recommended in education, health, law, and child development, to be undertaken by an alliance of government, voluntary organizations, the corporate sector, media and funding agencies.

Stressing UNFPA's commitment to improving conditions for girls, Dr Wasim Zaman said the adolescent girl in India is at constant risk of early marriage and early and repeated childbearing, which damages her own health and has an adverse effect on the health of her children.

Sonia Gandhi, chairperson of the Rajiv Gandhi Foundation, was joined by adolescent girls throughout India in opening the conference. The girls, who have participated in programmes supported by CEDPA and UNFPA, spoke with pride about their new abilities, independence, and confidence and the respect and support given to them by their families.

Girls up to the age of 19 comprise about one-quarter of India's population. Of the 12 million girls born in India every year, three million or 25 per cent die before the age of 15. One-third of these deaths take place in the first year of life. Female feticide and infanticide have become matters of the gravest concern. Almost 300,000 more girls than boys die annually according to UNICEF. The sex ratio has consistently fallen from 972 females per 1,000 males in 1901 to 927 per 1,000 in 1991.

Though the legal age of marriage in India is 18, many girls are much younger when they marry, said Seema Chauhan of CEDPA. Of the 4.5 million marriages every year, three million involve girls who are 15-19. However, in some districts of Rajasthan, more than 45 per cent of girls ages 10-14 are married. In Bihar, Madhya Pradesh, and Uttar Pradesh, about 50 per cent of girls are married before they reach the age of 16.

Adolescent marriages are synonymous with adolescent childbearing. Women 15-18 account for up to 17 per cent of births. An adolescent's risk of dying during childbearing is high. Girls 10-14 are twice as likely to die from pregnancy-related causes as women in their early 20s. Undernourished, underweight adolescent mothers place their children at greater risk. Several studies have shown that 30-40 per cent of babies born to underweight mothers are premature, low birth weight, or still born.

Gender discrimination affects girls from infancy through adolescence, Ms Chauhan said. As a result, far fewer girls than boys are educated. Only 39 per cent of girls over the age of 7 are literate as opposed to 64 per cent of boys. Only 21 per cent of girls ages 11-14 are in school. Many forces combine to spell an early end to education for girls, but early marriage and childbearing are major reasons.

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BANGLADESH BOOSTER

The United States Agency for International Development (USAID) has joined forces with Pathfinder International, to undertake a seven-year US$35-49 million programme to deliver integrated family planning and maternal/child health services in rural Bangladesh. Responsibility in managing these programmes will gradually be transferred to local Bangladeshi institutions - a key component of USAID's New Initiatives in Population and Health project for the country.

USAID's involvement with the Bangladesh government and the National Family Planning/Maternal and Child Health Programme have been remarkably successful - the total fertility rate (the average number of children per woman) has been reduced from about 6.0 in 1980 to 3.5 in 1995. Infant mortality also dropped from about 110 per 1,000 live births in the mid 1980s to 87 per 1,000 in 1994, coinciding with an expanded immunization programme.

The New Initiatives Programme will build upon these successes, promoting a cost-effective clinic-based service which will integrate family planning and reproductive health, including maternal and child health services.

Pathfinder has formed a partnership with two Bangladeshi organizations, the Bangladesh Rural Advancement Committee (BRAC) and the Bangladesh Centre for Communication Programmes (BCCP) in order to achieve the programme's goals, which include reaching a near-replacement fertility level (2.3 children per woman) and increase the use of modern contraceptives.

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HELPING REFUGEES

With over 44 million refugees and internally displaced people worldwide - the majority of them women and children - a new consortium of non-government agencies is now working to help meet their needs for reproductive health care. They are responding to the fact that once other basic needs are met, the lack of reproductive health services is a major cause of disease and death.

First set up in 1994, the five agencies involved are now attracting much support for work in some 20 countries including the former Yugoslavia, Sri Lanka, Vietnam and Hong Kong. Africa's special refugee problems have led to projects in Guinea, Ivory Coast, Zaire, Tanzania, Mozambique, Sudan, Eritrea, Ethiopia and Kenya.

Though the international community recognized the special reproductive health problems of refugee women at the UN Women's Conference in Copenhagen in 1980, it has taken a long time to mobilise any concerted effort to deal with them. A lead role in setting up the Reproductive Health for Refugees Consortium was taken by the Mellon Foundation. Consortium members are the Women's Commission for Refugee Women and Children, Marie Stopes International, Care, the International Rescue Committee and John Snow Inc.

Their efforts have largely been in the area of education, training and advocacy, and helping local groups to take services into the refugee camps and to displaced people fleeing from persecution and violence. The needs go far beyond family planning and include prevention and treatment of sexually transmitted diseases, including AIDS, protection from sexual violence, safe motherhood services and emergency obstetric care.

According to Lyndall Sachs of Marie Stopes International (MSI), many refugee women are at the mercy of rape or

forced into prostitution, adding to the traumas of refugee life. Others resort to unsafe abortion in the absence of family planning services. Men and adolescents also need reproductive health care.

MSI is developing a Minimal Initial Services Package for refugee communities as part of the general effort to train relief workers. Also now available is a field manual from UNHCR and UNFPA and a consortium guide to assist local staff to assess needs.

Contact: Lyndall Sachs, Refugees Initiatives, Marie Stopes International, 153-157 Cleveland Street, London W1P 5PG. Tel:+44 (0) 171 574 7400, Fax:+ 44 (0) 171 574 7414.

INVESTING IN WOMEN

Unless women are placed at the centre of efforts to increase food production, vital opportunities to meet the world's present and future food needs will be missed, says a new report *Food for the Future: Women, Population and Food Security*, by the United Nations Population Fund (UNFPA).

Much of the food available to poor families comes from shrinking and fragmented farmsteads, backyard gardens, even abandoned lots in the middle of cities. Many of today's small-scale food producers and a disproportionate number of the world's poor are women.

Women provide much of the food grown for home consumption in the developing world. In sub-Saharan Africa, women grow and sell 80 to 90 per cent of the country's food, They produce 50 to 60 per cent of Asia's food, 46 per cent of the Caribbean's and more than 30 per cent of Latin America's.

"Most countries do little to encourage women farmers: agricultural investment and technical assistance policies assume that recipients are men, and land-holding and inheritance practices are biased in their favour," says the report despite the fact that there are more women-headed households than ever before.

"Support for women's reproductive rights and reproductive health will have a decisive impact on the growth and eventual size of world population," says the report. Nutrition is essential to reproductive health and yet only 20 to 40 per cent of women in developing countries can rely on an adequate diet.

"As countries struggle to feed increasing numbers of people, policy-makers must acknowledge both women's vital role as food producers and the contribution to the health and nutritional status of their families and communities." The report argues that providing women with access to credit, markets and technical advice, as well as education and health care, could both improve the food supply of the world's poorest people and help them to escape poverty.

For a copy of the report contact: UNFPA, 220 East 42nd Street, New York, NY 10017, USA. Tel:+1 212 297 5026, Fax:+1 212 557 6416.

LIVING PLANET

The World Wide Fund for Nature (WWF) has marked its 35th anniversary with the launch of a new global conservation campaign: WWF 2000 - The Living Planet Campaign.

The campaign aims to inject a new dynamic into the conservation movement and involve people from all over the world in a concerted effort to slow down the growth of the 'human footprint' on our planet in the 21st century.

WWF points out that this footprint is currently increasing faster than ever before: "Each year we cut down or burn 17 million hectares of forest, emit 23 billion tonnes of carbon dioxide (the main greenhouse gas), and kill 27 million tonnes of marine creatures that get accidentally caught up in industrial fishing nets and dumped back in the sea."

The campaign has identified around 200 'ecoregions', from the American Everglades to the dry forests in Madagascar, which are crucial to conserving nature into the next century. WWF scientists estimate that if these regions (known as the Global 200) are conserved, samples of 95 per cent of the Earth's biodiversity will survive into the next millennium. It plans to do this by establishing partnerships with governments, businesses and individuals.

The campaign aims to inspire donations of 'Gifts to the Earth' , such as that announced by the President of the Russian Republic of Sakha (Yakutia), an area roughly the size of western Europe, much of which lies within the Arctic Circle. President Nikolaev, pledged to protect 700,000 square kilometres - more than 25 per cent of the republic's total land mass - by the year 2000 as his Gift to the Earth. Most of Yakutia is covered by virgin forest, home to brown bears and wolves, and an area that features on the campaign's Global 200 list.

Contact: WWF, The Living Planet campaign, Keizersgracht 62-64, 1015 CS Amsterdam, The Netherlands. Tel:+ 31 20 520 7533, Fax:+ 31 20 520 7532 Email: 10624.3564@compuserve.com

Associates' News is compiled by **Maya Pastakia** *to whom all contributions should be addressed.*

CORRECTION

Brazil's Aracruz Company produces 3 per cent of the world's wood pulp, not 23 per cent, as stated in Vol 5/4.

LETTER: DAMS AND DISTRESS

Sir, I have admired your magazine since it was first published, and all the editions produced so far have been a great source of information and inspiration about human population issues.

Having just read Vol 5/3, I am very disappointed that you accepted the article called Dams and Distress for Kingdom in the Sky by Korinna Horta and Scott Coverdale, without checking their facts or getting a more balanced view from either of the two governments who have embarked on the Lesotho Highlands Water Project (LHWP), or from others involved in this ten-year-old undertaking.

I am a member of the Panel appointed to monitor the environmental aspects of the LHWP. To date our Panel has produced nine reports, all of which are available in the public domain. The Environmental Action Plan (EAP) of the Project, formulated in 1988, sets new and very high standards for projects of this nature, especially in an African context.

There is no doubt that southern Africa's future survival depends entirely on the wise use of water resources. Major engineering works to move water to critical areas that provide economic growth for the benefit of the whole subregion are inevitable. Lesotho does not 'own' the water of th. Senqu/Orange system - it is a shared regional resource. Under different circumstances South Africa could have chosen to abstract water after the river leaves the borders of Lesotho. The scheme as presently formulated makes it possible for Lesotho to benefit in a multitude of ways.

Our panel reports have consistently highlighted the deficiencies and delays in delivering compensation and benefits to project-affected people. But these problems are not because of the deliberate default or malicious intent - they are the result of human frailty within the LHDA, as social agendas struggle to keep up with technical deadlines in the biggest engineering project currently under way on the African continent.

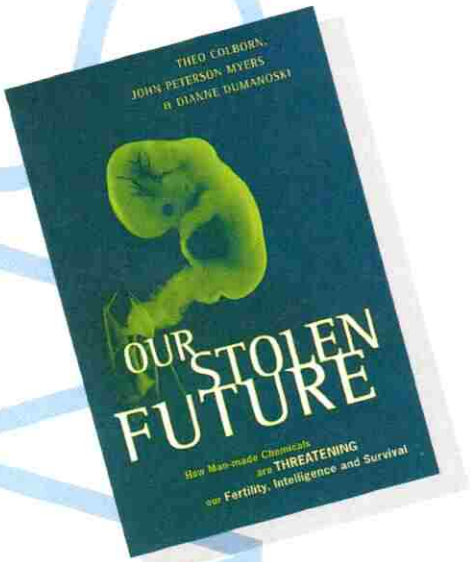
The Lesotho Highlands Water Project is not perfect but it seeks to establish new standards of concern for affected communities. As such, it is a model that needs to be fairly tested and judged by the world. The article in your magazine is unbalanced and misleading.

Dr John Ledger, Director, Endangered Wildlife Trust, South Africa

Korinna Horta and Scott Coverdale reply:

We agree with Dr Ledger that the Lesotho Highlands Water Project initially set out important standards for the rehabilitation of affected communities. However, the good intentions have not been followed up with action. The World Bank itself states that the Environmental Action Plan, which includes a rural development plan to help local people re-establish their livelihoods, is the "sick man" of the project. As a result, the World Bank is now conditioning funding for the next phase of the project on evidence that the deep-running social and environmental problems of the first project phase are being addressed.

Books


THEO COLBORN,
JOHN PETERSON MYERS
& DIANNE DUMANOSKI
OUR STOLEN FUTURE
How Man-made Chemicals are THREATENING our Fertility, Intelligence and Survival

SEX AND SURVIVAL

Our Stolen Future
Theo Colborn, Dianne Dumanoski, John Peterson Myers
Dutton, New York/Little Brown, London, 1996, £18.99

The subtitle of this book is 'Are we threatening our fertility, intelligence, and survival? - A scientific detective story.' Its basic premise is that environmental pollutants, in particular oestrogen-mimicking pesticides and plasticizers, are lowering men's sperm counts, reducing women's fertility in various ways, and even affecting our children's development in the womb, decreasing their fertility and intelligence.

Theo Colborn, a senior scientist at the US World Wildlife Fund - her work on endocrine-disrupting chemicals provides the basis of the book - and Pete Myers, director of an environmental foundation, were both involved in the conference on endocrine disruption held in Wingspread, Wisconsin in 1991, the consensus statement of which forms the appendix of the book. Dianne Dumanoski is an environmental journalist. The foreword is by US Vice President Al Gore, who hails the book as a second Silent Spring. I very much doubt that it will achieve the same impact.

To argue their points, the authors go into great detail about the harmful effects on various kinds of wildlife caused by accumulations of the now restricted PCBs (polychlorinated biphenyls) in the food chain, the effects of DDT and dioxins both in the wild and on laboratory animals, and the repercussions of the DES (diethylstilbestrol) scandal. (DES is an artificial oestrogen prescribed in the 1950s to pregnant women threatening to miscarry which caused abnormalities and cancers of their daughters' reproductive systems.)

Having gone over this well-trodden ground, the authors move on to look at the modern synthetic chemicals which have more recently been found to mimic oestrogen. Polystyrene and PVC (polyvinyl chloride) contain chemicals called nonylphenols as an antioxidant. These are also found in food packaging, and as breakdown products of industrial detergents, pesticides, and what the authors coyly describe as 'personal care products'. Another oestrogen mimic, bisphenol-A, has been found to leach from the polycarbonates used in plastic bottles and from the plastic lining used in food cans to prevent metal contamination.

Many of these oestrogen-mimicking chemicals are over 1,000 times as potent as estradiol and even tiny quantities could be harmful to animals and humans. The book points out that considerable quantities of these have got into the water supply, causing fish to show characteristics of both male and female, as well as other bizarre malformations. Whales in the St Lawrence were found to have both malignant and benign tumours, cysts, ulcers, and infections. Panthers and alligators in Florida, bald eagles nesting along the Great Lakes and seals in the Baltic all show evidence of disease and malformations caused by exposure to oestrogen-mimicking hormones. The authors also argue that these chemicals may be implicated in rising cancer rates among humans.

More controversial perhaps is the chapter discussing falling sperm counts among men. The book refers to the widely reported Danish study published in the British Medical Journal in September 1992 which reviewed 61 studies involving almost 15,000 men from 20 countries in all six continents. This found that the average male sperm count appeared to have fallen by 50 per cent between 1940 and 1990. Other research which has disputed this is not mentioned. (The recent findings of Harry Fisch and others - that sperm counts in three US cities had remained stable between 1970 and 1994 - were no doubt too late for this book.) The authors also quote studies showing an increase in abnormalities of the male reproductive system such as undescended testicles and higher rates of testicular and prostate cancer. They argue that these, too, could be caused by oestrogen-mimicking chemicals in the environment - although other scientists again disagree.

This book is written in a racy style, which makes it difficult for the more informed reader to extract the nuggets of new information which exist. But whatever doubts there may be about their thesis and presentation, the authors make a convincing case that we should not leave it too late before taking action to ban or restrict these chemicals. When such a precious thing as fertility and the future of the species is at stake, it would be better to over-react than to delay.

Maggie Jones

Maggie Jones is a freelance writer and author of *Infertility* (Piatkus Books) and *Choosing Older Motherhood* (Vermilion)

POPULATION STRATEGIES

Population and Strategies for National Development
Gayl D. Ness and Meghan V. Golay
Earthscan, London, 1996, £12.95

Coping with Population Challenges
Louise Lassonde
Earthscan, London, 1996, £14.95

The Future Population of the World
Wolfgang Lutz
Earthscan, London, 1996, £24.95

The Earthscan Reader in Population and Development
Simon Kuznets et al
Earthscan, London, 1996, £19.95

These four titles from Earthscan make a rich meal for all who feared that concern with human numbers was on the wane.

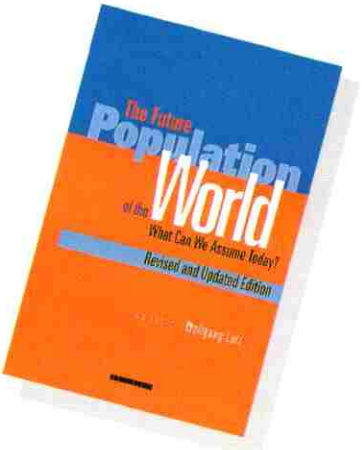
The first, by Gayl Ness and Meghan Golay, complements another manual, published by IUCN, *Our People, Our Resources* (Barton et al, 1996), which provided ideas for building bridges between population and sustainable development at a local level. This new book is more of a guide to national planning in this area.

Aimed primarily at those directly concerned with development planning and environmental conservation, its thoughtful dissection of the subject makes it a useful primer for students as well. Unusually, it includes some highly specific ideas for setting up Population Environment Networks of interested professionals, which have yet to be tested.

Critics of this approach will no doubt argue that planning is dead; that the market rules. Demographic and environmental realities may force a more thoughtful response.

Louise Lassonde's book is a detailed review of the Cairo Conference on Population and Development, its background and its outcome. More importantly it is a deeply thought out critique of the Programme of Action agreed in Cairo. In three final chapters, the author identifies the inconsistencies in the document and what she sees as its failure to deal with the development side of the equation or to face up to the implications of demographic change, through the concentration on reproduction and women.

In her view "the shrinking of the population perspective carries with it the risk that we shall miss the real challenges of our time...potential changes that could provide 20 per cent of the world's popu-

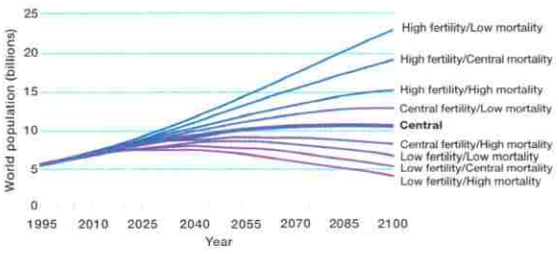


lation with a better quality of life, while 80 per cent revert to conditions that are best not described."

The Future Population of the World is a revised and updated edition of the book edited by Wolfgang Lutz first published in 1994. As such, it is probably the most authoritative collection of essays on future population trends to be found, including speculation on future fertility and mortality in developing countries and future inter-continental migrations. Lutz himself concludes that the world is likely to house around 10 billion people by 2050 and to stabilize at less than double today's population. He warns that if we do succeed in achieving the desired low fertility-low mortality scenario in the years ahead it could provide an immense dilemma of an ageing world, where by the end of the next century 42.5 per cent of the population would be over 60.

It is difficult to know quite who *The Earthscan Reader* is directed at. Almost certainly not the general public, nearly all of whom will find these demographic essays rather indigestible. The demographers, in turn, will be very selective about which of these contributions to tackle. However, several of the eminent contributors do not hesitate to take on themes well outside their demographic expertise and few could resist astronomer Fred Hoyle's speculations that within 5,000 years humans will have evolved, through a series of catastrophes into what is, essentially, a new species, highly sociable and with much greater intelligence. So there.

John Rowley



Alternative projected paths of world population size

Films

PEOPLE POWER

Ben Ludovici, a fisherman in the Central Visayas Region of the Philippines, is one of the stars of **Investing in People**, the latest 25-minute *People & the Planet* video. With his family, he has now planted some 30,000 mangrove trees as part of a project aimed at reforesting the coast and reviving the local fisheries.

His story, and others in the film, illustrates the fact that the most successful aid projects are invariably those in which local people are involved and consulted - and where in many cases, the help goes straight to the people. As the commentary says: "Given the right support, local people can be the best protectors of the environment."

This theme is illustrated also in West Java, where the people of Salagedang village have used a well established local technology to build a stone road to the nearest highway, and thus open up a market for their produce. By entrusting the funds to the villagers and allowing them to decide how to use it and how best to sort out the problems involved the achievement is theirs, and its long-term viability is assured.

Interviewed for the film, Dr Grazia Borrini-Feyerabend, Head of the Social Policy Group at IUCN, said "Development cannot be ordered by a few people in air-conditioned offices and then carried out at the local level with nothing in between...(Governments and aid agencies) must figure out what actually has organic roots in society and match the needs and resources that are available there."

Investing in People is available from TVE at the address given elsewhere on this page, along with three other *People & the Planet Videos*. These are **Victory for Women** (on the outcome of the Cairo Conference on Population and Development), **Learning for Life** (on the education of women and girls) and **Calling the Shots** (on how women are finding new ways of communicating).

NOT THE NUMBERS GAME

Like teenagers the world over, they're moaning about their parents. But here, in Kapchorwa - home of the Sabiny people in the remote eastern mountains of Uganda - the argument turns on what is, potentially, a matter of life and death. "A women who has been circumcised can milk a cow," proclaims one girl, "But a girl who has *not* been circumcised cannot milk a cow. Parents say that if you milk a cow, the cow will die." "They are just trying to *harass* you," retorts her classmate, Justine, "so you are forced into circumcision." In the end, they all agree, the practice will only stop when both their parents and the wider community in Kapchorwa can all *agree* it is harmful, and that abolishing circumcision is not a wholesale attack on their culture.

The teenagers' exchange takes place in a scene from Charlotte Metcalf and Irene Zikusoka's *The Cutting Edge* - one of six short films in the series *Not the Numbers Game* that TVE made to mark the second anniversary of the Cairo Conference on Population and Development (ICPD) last September. The film explores the impact of the Reach programme which has prompted a radical turnaround in the Sabiny people's previously entrenched attitude towards circumcision (see page 19).

But while the Sabiny story is undoubtedly a success story, the international community still has far to go to live up to the challenges laid down in the ICPD Programme of Action two years ago. With *Not the Numbers Game*, we deliberately set out to look at progress - or lack of progress - on those challenges. We wanted to find out how the governments of six different countries - Cambodia, India, Indonesia, Uganda, Bosnia and Peru - were measuring up.

Inevitably, it was a pretty mixed picture. In India, Nupur Basu's thoughtful film looked at women's literacy campaigns in previously secluded Muslim enclaves of Kerala at the effect of over 40,000 women being elected to the *panchayats* or local village councils and the increased coverage given to population issues by the Indian media. Together such changes are helping to empower women across the continent.

In Indonesia, Nam Achnas' film explored the effects of globalization on women's lives. Do the new job opportunities opened up by multinational companies looking for cheap labour in the developing cities of Indonesia represent economic freedom for poor girls from rural areas - or just another kind of oppression and exploitation? Even in Bosnia, against the stark backdrop of the violations suffered by so many women during the four-year civil war, Nada Mehmedbasic's emotional film recorded the extraordinary courage of three women who had fought to preserve their basic humanity and rebuild their family's lives.

But in another war-torn country, Cambodia - 'The Land of Widows' - the picture was darker. Poverty, lack of basic health services, and the extreme gender imbalance that exists after the genocide inflicted by the Khmer Rouge regime all add up to a desperate situation for many women.

Our last film was set in Peru. We wanted to go behind the statistics and uncover the reasons for Peru's (and much of Latin America's) soaring teenage pregnancy rates. Ana Diaz Costa's harrowing film told the story of Janette, the eldest of six sisters born into a poor family in Lima. With no sex education at school and entirely ignorant of the facts of life, Janette was seduced by her 25-year old neighbour, Marco Antonio, at the age of 17; thrown out of her home by her parents, and left to bring up her baby Solange on her own. And that was only the beginning of her troubles.

The one light at the end of the tunnel in Janette's story was that the film-makers put her in touch with INPARES, an organisation that provides health and information services for young people in Peru, to allow them to explore their own sexuality safely, happily and responsibly.

Jenny Richards

Jenny Richards is Deputy Director of TVE.

Not the Numbers Game is available, for broadcast or non-broadcast use, in English, French and Spanish from TVE, The Centre for Environmental Communications, Prince Albert Road, London NW1 4RZ, Tel: +44 (0)171 586 5526, Fax: +44) (0)171 586 4866, Email: TVE-dist@tve.org.uk

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People & the Planet

Our next issue will report on coral reefs: rainforests of the sea.

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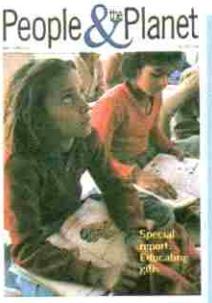

Volume 2 Number 2
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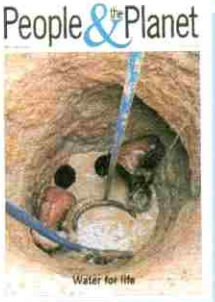

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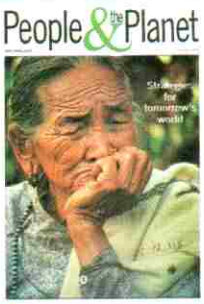

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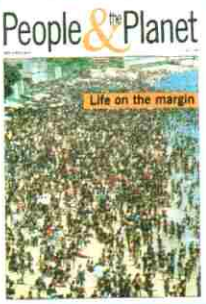

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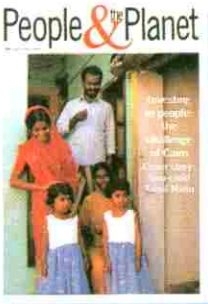
Investing in people



Volume 3 Number 4
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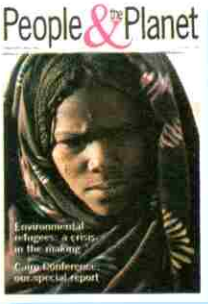

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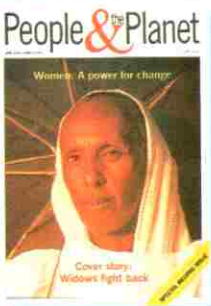

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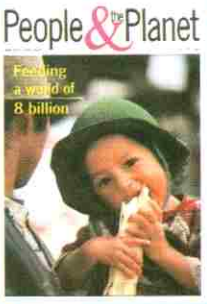

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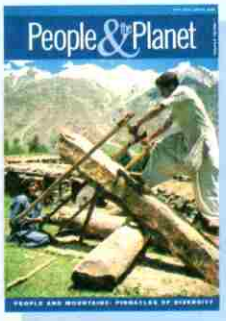

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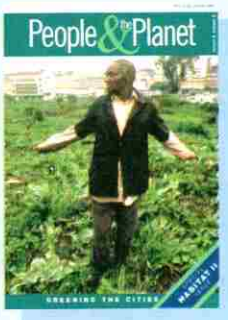

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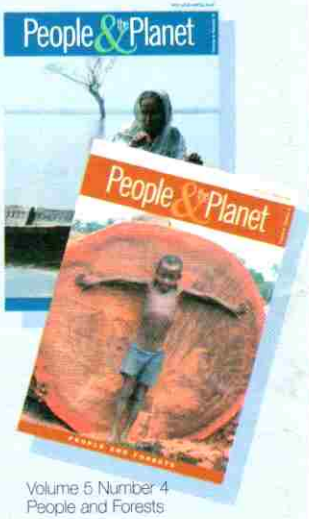
Rivers of life



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